Child Intake

Name of child: _____ Date:_____

Date of birth: _____ Gender: M F

Address: _____
_____
_____
_____

Email address: _____

Would you like to receive our email newsletter? Y N
(We will not share your email address with anyone else)

Phone number: Home: _____ Cell: _____
Work: _____

Would you like to receive confirmation emails when you schedule/change appointments?
Yes No

Our office will send appointment reminders 48 hrs prior to your appointment, **you must opt for at least 1:**

- ☐ Phone call- preferred phone to contact: _____
- ☐ Email
- ☐ Text message

Optional additional reminders (we can send you as many as you like):

- ☐ Email 24 hours before
- ☐ Email 3 hours before
- ☐ Text message 24 hours before
- ☐ Text message 3 hours before
- ☐ Phone call 24 hours before

Insurance Provider

Primary: _____ Secondary: _____

- ☐ I prefer to bill my own insurance
- ☐ I prefer the clinic to bill my insurance on my behalf

Emergency contact: Name: _____

Relation: _____ Phone number: _____

How did you hear about the clinic? _____
_____

Other health care providers the child is seeing (ie. medical doctor, chiropractor, etc):

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____)_____	(____)_____	(____)_____

Child's health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

List past or present serious conditions, illnesses, injuries and hospitalizations with approximate dates:

_____
_____
_____
_____
_____
_____
_____

Does the child have any allergies (medications, environmental, etc)?

_____
_____
_____
_____

List all current medications with dosage if known (including prescription and over the counter drugs, vitamins, supplements, herbs, homeopathics, etc):

_____
_____
_____
_____
_____
_____

Does the child frequently use any of the following (please check yes or no):

	Yes	No	If yes, how often
Tylenol/Advil	____	____	_____
Other painkillers	____	____	_____
Antacids	____	____	_____
Laxatives	____	____	_____

Please list past prescription medications and indicate time of usage:

_____
_____
_____
_____

Does the child get regular screening tests done by another doctor? (blood tests, etc) Y N

How long has it been since the child last saw a medical doctor? _____

How many times has he/she been treated with antibiotics? _____

Please indicate which vaccinations the child has received:

- □ DPT (diphtheria, pertussis, tetanus)
- □ Haemophilus influenza B
- □ MMR (measles, mumps, rubella)
- □ Hepatitis A and B
- □ Flu shot

Other: _____
Has he/she had any adverse reactions to vaccinations? _____
_____

Family Health History

Please indicate if a close relative of the child (parent, grandparent, sibling, etc) has had any of the following:

	Family Member		Family Member
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Diabetes		Other	
Cancer			

Diet

Does the child have any food allergies or sensitivities? Please list:

_____
_____
_____

Does he/she have any food restrictions? (vegetarian, vegan, religious, etc)

_____
_____
_____

Describe a typical day's diet:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages/water _____

Environment

Hobbies _____

Does the child play sports? Y N if yes, how often and what do they do?

_____
_____

Is the child exposed to second hand smoke? Y N

Is the child frequently exposed to animals (pets, daycare)? Y N

Is he/she regularly exposed to toxins or hazards (home, hobbies, etc)? Y N
Please describe: _____
_____

How many hours does the child sleep each night? _____
Does he/she sleep well, if no, please describe? _____
_____
_____

If the child is in school, does he/she enjoy school and how is the child doing in school? _____
_____
_____
_____
_____

Describe the emotional state of the child's home: _____
_____
_____
_____
_____

Is there anything that you feel is important that has not been covered? _____
_____
_____
_____
_____

Check the conditions that the child is currently experiencing, or has experienced often in the past.

	current	past
General Symptoms		
Loss of consciousness	□	□
Numbness / tingling	□	□
Fever/chills	□	□
Sweats	□	□
Fainting	□	□
Seizures/convulsions	□	□
Dizziness	□	□
Frequent colds / flus	□	□
Loss of weight	□	□
Fatigue/weakness	□	□
Head / Neck		
Headaches	□	□
Head injury	□	□
Vision problems	□	□
TMJ concerns	□	□
Earaches	□	□
Decreased hearing	□	□
Sinus problems	□	□
Difficulty swallowing	□	□
Frequent colds	□	□
Hayfever	□	□
Skin		
Rashes / Eczema	□	□
Itching	□	□
Acne	□	□
Bruise easily	□	□
Dryness	□	□
Boils / Hives	□	□
Change in mole	□	□
Night sweats	□	□

	current	past
Respiratory		
Chronic cough	□	□
Shortness of breath	□	□
Sputum	□	□
Wheezing	□	□
Breathing problems	□	□
Asthma / Bronchitis	□	□
Allergies	□	□
Cardiovascular		
Bleeding disorders	□	□
Anemia	□	□
Chest pain	□	□
Murmors	□	□
Palpitations/fluttering	□	□
Poor circulation	□	□
Heart problems	□	□
Genitorurinary		
Pain on urination	□	□
Blood in the urine	□	□
Bedwetting	□	□
Urgency	□	□
Increased frequency	□	□
Hesitancy	□	□
Frequent infections	□	□

	current	past
Gastrointestional		
Trouble swallowing	□	□
Poor digestion	□	□
Indigestion	□	□
Excessive hunger	□	□
Change in thirst	□	□
Change in appetite	□	□
Belching or gas	□	□
Nausea / Vomiting	□	□
Abdominal pain	□	□
Constipation	□	□
Diarrhea	□	□
Blood in stool	□	□
Black, tarry stool	□	□
Hernias	□	□
Infections / Illnesses		
Herpes	□	□
Hepatitis	□	□
Plantar warts	□	□
Tuberculosis	□	□
HIV / AIDs	□	□
Cancer	□	□
Muscles and Joints		
Stiff neck	□	□
Backache	□	□
Swollen joints	□	□
Foot trouble L / R	□	□
Shoulder pain L / R	□	□
Elbow pain L / R	□	□
Wrist pain L / R	□	□
Hip pain L / R	□	□
Knee pain L / R	□	□
Weakness / loss strength	□	□
Muscle spasms/cramps	□	□