Pediatric Chiropractic Intake Form

Dr. Rob Thomson DC

Present Complaint:

When did this begin?__________________ Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N Describe: _________________ _

Current medications: ________________ _

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain: ---------------------------

Medications taken during pregnancy: ___________ _

Cigarettes or alcohol during pregnancy: Y N Birth Intervention: Forceps Vacuum (-Section

Complications during delivery? Y N Explain:____________________________ _

Genetic disorders or disabilities:__________________________________ _

How many times has your child been prescribed antibiotics in the past 6 months? ___ Total during lifetime:__ _

Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long: ____ _

Formula Fed: Y N How long: ____ _

Introduced to: Solids at ___ Months

Cows milk at ____ Months

Food Allergies or Intolerances: Y N

List:______________ _

Childhood Diseases:

Chicken Pox: Y N Age:_____ _

Rubella: Y N Age:_____ _

Rubeola: Y N Age:_____ _

Mumps: Y N Age:_____ _

Whooping Cough: Y N Age:_____ _

Other: ______ Age:____ _

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

______ Respond to Sound

______ Respond to Visual Stimuli

______ Hold Head Up Alone

______ Sit Up Alone

______ Cross Crawl

______ Stand Alone

______ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N

Explain: ____ _

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N Explain:___________________

Other traumas not described above? Y N Explain:___________________

Prior surgeries? Y N Explain:___________________

Review of Systems

Please check if your child has had any of the following:

____ Headaches	____ Postural Imbalances	__ Growing Pains	____ Scoliosis	____ Tonsillits
____ Asthma	____ Torticollis	____ Ear Infections	____ Seizures	__ Sleep Problems
__ Digestive Problems	__ Bedwetting	__ POD/Autism	__ ADD/ADHD	__ Frequent Fever
____ Colic	__ Learning Difficulties	____ Acid Reflux	__ Hip Dysplasia	__ Allergies

How would you rate your child's diet? __ Well Balanced __ Average __ High sugar/processed foods

Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps:._________ hours per night _______ hours per day/naps

Sleep Quality: __ Good __ Fair __ Poor

Imagine this picture is your body. Can you color the area that is hurting you right now?