

# ARCHEUS Chiropractic and Wellness

## Pediatric Patient Intake

### Child Information

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female

Family Medical Doctor: \_\_\_\_\_ Location: \_\_\_\_\_

### Parent or Gaurdian info

Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employment Status:  Employed  Full Time Student  Part Time Student  Other

Please describe your occupation(s): \_\_\_\_\_

### Chiropractic Health History

Has your child received chiropractic care in the past? Y / N When? \_\_\_\_\_

Why? \_\_\_\_\_ Chiropractors Name: \_\_\_\_\_

Primary reason(s) for seeking chiropractic care today: \_\_\_\_\_

Have they seen anyone else for this condition? Y/N Who? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Past Health History

Check any of the following conditions your child has suffered from during the last 6 months:

- |   |                                       |   |  |  |
|---|---------------------------------------|---|--|--|
| <input type="checkbox"/> Ear Infections   | <input type="checkbox"/> Scoliosis    | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Chronic Colds   | <input type="checkbox"/> Headaches         |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> ADHD         | <input type="checkbox"/> Recurring Fevers   | <input type="checkbox"/> Colic           | <input type="checkbox"/> Growing/Back Pain |
| <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Whooping Cough    |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Rubella      | <input type="checkbox"/> Rubeola            | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Other             |

Please list any other health conditions your child has experienced in the last 6 months: \_\_\_\_\_

Please list any current medications or supplements and the reasoning behind them: \_\_\_\_\_

Number of Doses of Antibiotics your child has taken:  **None**

Past 6 months: \_\_\_\_\_ Total during his/her lifetime: \_\_\_\_\_

**Allergic/Immunologic**  No to all

Hives  Immune Disorder  HIV/AIDS  Allergy Shots  Other

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Food Intolerance  Medication intolerance  Other

Please list all known allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child received any vaccinations? Y/N If yes please list any and all that you can remember:  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

The first years of life are when your child is most vulnerable to stress and should 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  
\_\_\_\_\_ Sit Up      \_\_\_\_\_ Cross Crawl      \_\_\_\_\_ Stand Alone      \_\_\_\_\_ Walk Alone

Did your child reach all set goals on time?  Yes  No

If No what goals were slow or not reached? \_\_\_\_\_

Any prior surgeries?  Yes  No

If yes please explain: \_\_\_\_\_  
\_\_\_\_\_

**Prenatal History:**

Name of Obstetrician/Midwife: \_\_\_\_\_

Complications during pregnancy?  Yes  No

If Yes please explain: \_\_\_\_\_

Ultrasounds during pregnancy?  Yes  No Number: \_\_\_\_\_

Medications during pregnancy/ delivery?  Yes  No

If yes please list: \_\_\_\_\_

Cigarette/ Alcohol use during pregnancy?  Yes  No

Location of Birth:  Hospital  Birthing Center  Home  Other: \_\_\_\_\_

Birth Intervention:  Forceps  Vacuum Extraction  Cesarean Section:  Emergency  Planned

Complications during delivery?  Yes  No

If yes please explain: \_\_\_\_\_

Genetic Disorders or Disabilities?  Yes  No Explain: \_\_\_\_\_

Was delivery within 2 weeks of due date?  Yes  No # of days premature/late: \_\_\_\_\_

**Feeding History:**

Breast fed:  Yes  No How long? \_\_\_\_\_

Formula Fed:  Yes  No How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced: Solids at: \_\_\_\_\_ Months, Cows or Goats milk at: \_\_\_\_\_ Months

Any special diet?  Yes  No

What and for What reason? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Lifestyle of Parent(s)**

**Physical**

How often do you exercise?  Daily  Often  Occasionally  Rarely  Never Hours per week?: \_\_\_\_\_

Do you stretch daily? Y/N Do you pay attention to your posture? Y/N

Please list your hobbies or activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bio-Chemical**

Do you smoke or have you in the past? Y/N If yes how often and how much? \_\_\_\_\_

Do you use / consume?  Tobacco  Alcohol  Caffeine How often day/week? \_\_\_\_\_

Do you eat prepared, processed or fast foods? Y/N How often? \_\_\_\_\_

Do you consume carbonated or drinks high in sugar daily? Y/N How often do you drink water? \_\_\_\_\_

Are you on any special diet? Y/N If yes for what reason? \_\_\_\_\_

Your diet emphasizes fruits, vegetables, whole grains, lean meats and other protein sources and is low in sugar and artificial sweeteners? Y/N please rate your diet 10 being healthy: 1 2 3 4 5 6 7 8 9 10.

**It is important that our patients and we have the same health objectives concerning chiropractic and wellness care. Regardless of what a disease or condition is called our practice objective is to eliminate a major interference to the expression of the body's internal ability to heal and thrive. By adjusting the spine, removing subluxations, we help restore the neurological communication of the brain to the body and improve the biomechanical supports of this system. With the addition of lifestyle, nutrition and exercise recommendations we support the healing of this system and therefore maximize the bodies inborn abilities, bringing you beyond the comfort zone of no symptoms and constantly challenge you to reach for optimal health! Your signature here verifies that the information provided on this form is complete and correct and that you are willing to begin your journey with chiropractic care!**

**Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**