LIGHTHOUSE CHIROPRACTIC

Pediatric Patient Intake Form

Patient name:_______________________________________ Age: _______ Birth Date:_______/______/______
Address:________________________________ City:_______________ State:________ Zip Code:________________
Name of Parents/Guardians: ____
Parents Home phone:_____________________ Work phone:______________________ Cell phone:______________
Email:____
Referred By: ____
Would you like this office to verify your health insurance coverage? ____________________________________

Consultation

Reason for seeking chiropractic care: ____
When did the problem begin: ____
Is this problem ___ Occasional ___ Frequent ___ Constant ___ Intermittent ___ Other __________________________
If the pain travels, where does it go? ____
What makes it better? ____
What makes it worse? ____
Is the problem worse during a certain time of the day? No Yes If Yes, when? ______________________________
Does this interfere with the child's ☐ Sleep ☐ Eating ☐ Daily routine ☐ Is this becoming worse? No Yes
If yes, how? ____
Other professionals seen for this condition? ____
Results with treatment? ____

Prenatal History for Infants and Newborns

Name of Obstetrician/Midwife ____
Complications during pregnancy: No Yes List: ____
Birth Intervention: ☐ Forceps ☐ Vacuum ☐ Caesarian: Planned or Emergency
Complications during delivery: No Yes ____
Medications during pregnancy: No Yes ____
Cigarette /Alcohol use during pregnancy: No Yes
Was the infant alert and responsive within 12 hours of delivery? No Yes
If No, please explain: ____
Birth Weight ___________ Birth Length ___________ APGAR scores ___________
Genetic disorders or disabilities? ____
Breast Fed: No Yes How Long? ________________ Formula Fed: No Yes How Long? __________________
Solids at ______ months Cow's milk at ______ months Food/Juice allergies or intolerances No Yes
At what age did the child: Respond to sound _________ Follow an object ____________ Hold head up ___________
Vocalize ___________ Sit alone ___________ Crawl ___________ Walk _________ Sleep Through Night ___________

Medication History

Previous Chiropractor: ___________________________________ Date of last visit & Reason: ___________________
____
Name of Pediatrician: ______________________________ Date of last visit & Reason: ________________________
____
Are you satisfied with the care your child received there? Yes No
Immunization History: ____
Reactions: ____
Check all drugs your child is taking including prescription and non-prescription drug
__Asthma medication __Tylenol __Advil/Iburofen __Cold tablets __Allergy Med
__ADHD Med __Painkillers __Anti-Depressants __ Other ______________________
Does your child take any Vitamins or Herbs? No Yes ____
Number of antibiotics your child has taken: Past 6 months __________ Total during his/her lifetime ________

Falls & Injuries

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc)
Is this the case with your child? No Yes
When was your child's most recent fall? ________________ What happened? __________________________
____

Which of the following sports have your child been involved in?

__ Football __ Basketball __ Soccer __ Gymnastics/Cheerleading __ Martial Arts
__ Running __ Horseback riding __ Other: _________________

Has your child ever broken a bone? Is no, which one? ____
Has your child ever been involved in an auto accident? No Yes Was there impact? No Yes
Were there injuries? No Yes (Dates/any treatment) ____
Has your child ever been seen on an emergency basis? No Yes (please list all) _______________________
____
Other traumas not described above? No Yes ____
Prior surgery: No Yes If yes, Type and Date: __________________________ Menses: No Yes Age: _____

Childhood Diseases & Illness

☐Acid Reflux	☐ADD/ADHD	☐Allergies	☐Anemia
☐Arthritis	☐Asthma	☐Autism	☐Backaches
☐Bed Wetting	☐Behavioral Problems	☐Blood Disorders	☐Broken Bones
☐Bronchitis	☐Car Accident	☐Chicken Pox	☐Chronic Colds
☐Chronic Ear aches	☐Colic	☐Constipation	☐Convulsions
☐Depression	☐Diabetes	☐Diarrhea	☐Digestive Problems
☐Dizziness	☐Ear Infection	☐Epilepsy	☐Fainting
☐Fatigue	☐Growing Pains	☐Headaches	☐Heart Trouble
☐Hernias	☐Hyperactivity	☐Hypertension	☐Jaundice
☐Loss of Balance	☐Loss of Smell	☐Mumps	☐Neck Pains
☐Poor Appetite	☐Poor Coordination	☐Recurring Fevers	☐Rubella
☐Scoliosis	☐Seizures	☐Shortness of Breath	☐Sinus
☐Sore Throats	☐Stomach Aches	☐Temper Tantrums	☐Urinary Problems
☐Walking Problems	☐Whooping Cough	☐Other:	

Authorization To Treat A minor

I ____________________________, Parent or legal Guardian of _________________________________
YOUR NAME (PRINT) CHILD'S NAME

Hereby authorize Ed Osgood, D.C. and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parents is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent/Guardian _______________________________________ Date: __________________