

PEDIATRIC INTAKE FORM-PLEASE PRINT

Child's Full Name: _____ SSN# _____ Date: _____
Parent #1 Name: _____ Parent #2 Name _____
Child's Home Address: _____ City: _____ State: _____ Zip: _____
Home Telephone: _____ Parent #1 Phone Work and/or Cell: _____
Parent #2 Phone Work and/or Cell: _____
Parent Email Address(es): _____
Whom may we thank for referring you? _____ Has he/she ever had chiropractic care before? _____ For
what problem? _____ Were the results satisfactory? Y No N/A

ADOPTION INFORMATION

Child's Age When Adopted _____ Date of Adoption _____ Known Health History of Child: _____

BIRTH INFORMATION

Birth Date _____ Sex _____ Birth Weight _____ Birth Length _____ Current Age of Child _____
Type of Birth: Vaginal ___ Forceps ___ Breech ___ Cesarean ___ Home ___ Birthing Center ___ Hospital ___
Any problems during pregnancy and/or labor? If you need more space please attach an additional page for that information.

APGAR Scores: _____ (1 min) _____ (5 mins) Jaundice (yellow) at Birth? _____ Cyanosis (blue)? _____
Congenital Anomalies/Defects: _____
Infant Feeding: Breast ___ Bottle ___ Formula ___ Other Food or Drink Information: _____

No. of Hours Child Sleeps Daily _____ Quality of Sleep: Good _____ Fair _____ Poor _____
Explain: _____
Number of Siblings _____ Siblings Name, Age and Sex: _____

HEALTH AND MEDICAL INFORMATION

Obstetrician and/or Midwife Name: _____ Location: _____
Pediatrician and/or Family MD Name: _____ Location: _____
Date of Last Visit to Dr: _____ Purpose of that Visit: _____

Immunization History _____

Has your child ever been treated on an emergency basis? _____ Please Describe: _____

Purpose of the appointment today with the Chiropractor: _____

Pregnancy History: _____

Delivery/Birth History: _____

Developmental History – At What Age Did the Child: Childhood Diseases – Age of the Child When Occurred:

Respond to Sound _____	Chicken Pox _____
Crawl _____	Rubella _____
Follow an Object with their Eyes _____	Rubeola _____
Hold Head Up _____	Whooping Cough _____
Stand _____	Mumps _____
Sit Alone _____	Measles _____
Walk Alone _____	Other _____

Has this child ever suffered from (please check any that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Backaches | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> "Growing Pains | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Any Other Problems List Below: |

Present Health History or Additional Information: _____

Surgery Information: _____

Medications: _____

Accidents: _____

Family Health History: _____

Accident Information: Is condition due to an accident? Y N date: _____ Type: Auto work home other

If this is due to an accident please notify the office to obtain the correct additional form

LIST ANY VISIBLE BUMPS, BRUISES, CUTS ETC. ON THE CHILD THAT WERE CAUSED BY THIS ACCIDENT?

INSURANCE

Insured Name: _____ Ins. Company: _____

D.O.B.: _____ Group Number: _____

Relationship to patient: _____ I.D. Number: _____

I certify that I and /or my dependants have insurance coverage with the insurance company listed above and assign directly to Dr. Jill Aardema at Flow Chiropractic, LLC all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. The consent will end when the current treatment plan or one year from the date signed below.

Signature of Patient Guardian or Personal Representative

Date

Print name of Patient Guardian or Personal Rep.

Relationship to Patient

I understand and agree that Flow Chiropractic has the right to refuse to accept my child as a patient at any time before treatment begins. The physical exam and x-rays are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept my child as a patient. If x-rays or other studies are necessary before treatment begins I will be notified. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT OR GUARDIAN SIGNATURE _____ DATE:

AUTHORIZATION OF CARE FOR A MINOR I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

PARENT/GUARDIAN SIGNATURE(S): _____

DATE

DATE

FOR DOCTORS USE ONLY

CC: _____

Location: _____

Onset/Trauma: _____

Mechanism of Injury: _____

Duration: _____

Current Symptoms: Pain Numbness Stiffness Weakness other: _____

Location: Left / Right / Bilateral _____

Quality of Symptoms: burning diffuse dull/aching localized radiating sharp
 shooting stabbing throbbing tightness tingling
 other: _____

Level of Impairment Due to Symptoms (resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (with activity): 0 1 2 3 4 5 6 7 8 9 10

Worse in morning midday afternoon night activity rest

Better in morning midday afternoon night activity rest

Other Aggravating or Relieving Factors: _____

Present % during the day: 0% 10 20 30 40 50 60 70 80 90 100%

Visual Analogue Pain: 0 1 2 3 4 5 6 7 8 9 10 (best and worse)

Job Performance: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do)

Recreation: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do)

ADL's: _____

Past Health History: _____

Prior Interventions: _____

_____ Paternal:

_____ Maternal: