PEDIATRIC INTAKE & HISTORY

HURST CHIROPRACTIC
· Natural Healthcare for Your Family ·

PATIENT INFORMATION

DC/CA

Name _____
(First) (Last) Preferred Name

Address _____

City _____ State _____

Sex ☐ M ☐ F Age ____ Date of birth _____

Primary Care Physician _____ at _____

Mother's Name _____

Mother's Phone _____

Father's Name _____

Father's Phone _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Person responsible for account _____

SSN _____ Employer _____

Who may we thank for referring you? _____

I authorize:

☐ All Doctors of Chiropractic within Hurst Chiropractic to perform treatment and diagnostic exams (which may include x-ray, surface electromyography, thermography, and orthopedic testing) on this minor.

☐ All Licensed Massage Therapists of Hurst Chiropractic to perform treatment and physical examination on this minor (massage only prescribed when clinically needed).

☐ Chiropractic and/or massage services for the minor in my absence.

Parent/Guardian Signature _____

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other _____

_____

If your child is already experiencing a symptom, please describe it:

What does it feel like? (check where appropriate)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — SEVERE SYMPTOMS

☐ Weakness ☐ Tingling

☐ Soreness ☐ Numbness

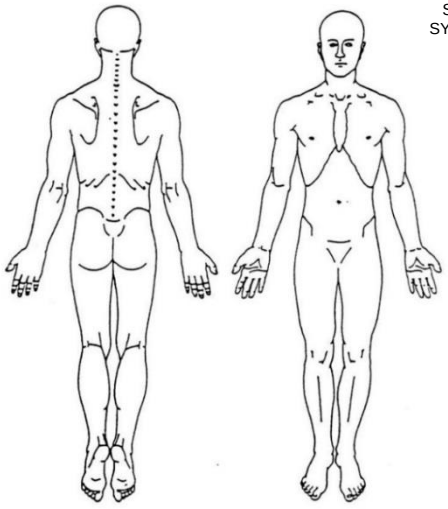
☐ Sharp ☐ Aching

☐ Cramping ☐ Tightness

☐ Spasm ☐ Headache

☐ Other _____

Where do they feel it:



Does anything make it better?

_____

Does anything make it worse?

_____

Who have they seen for this? No one Medical Doctor Other Chiropractor Physical Therapist Massage Therapist

Have they had a similar issue in the past? ☐ No ☐ Yes _____

Name _____ Date _____ DC/CA_____

BIRTH & EARLY CHILDHOOD HISTORY

Type of birth (check all that apply)

☐ Hospital ☐ Birth Center ☐ Home ☐ Vaginal ☐ Scheduled/Induced

☐ Breech ☐ Cesarean ☐ Epidural ☐ Assisted (forceps/vacuum extraction)

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

Hours of sleep each night: _____ Quality of sleep: _____

Have you vaccinated your child?

☐ No ☐ Yes ☐ As scheduled ☐ Delayed Schedule

Any history of:

☐ Asthma ☐ Colic ☐ Ear Infections ☐ Respiratory Infections ☐ Learning Disability

☐ Gastric Reflux ☐ Hyperactivity/ADHD ☐ Sensory Processing Disorder ☐ Autism Spectrum Disorder

PREVIOUS CONDITIONS, INTERVENTIONS & ALLERGIES

DIAGNOSED MEDICAL CONDITIONS (list)

_____

_____

_____

MEDICATIONS (list)

_____

_____

_____

ALLERGIES (list)

_____

_____

_____

SURGERIES/HOSPITALIZATIONS (list)

_____

_____

_____

What have they had done? ☐ Spinal X-rays ☐ MRI ☐ CT Scan ☐ Other _____ Where? _____

CHILDHOOD DISEASES & ILLNESSES

Has your child ever suffered from (check all that apply)?

☐ Abdominal pain
☐ Acne
☐ Anemia
☐ Arm problems
☐ Back Aches
☐ Bed Wetting
☐ Behavioral problems
☐ Broken bones
☐ Chronic Cough
☐ Chronic Ear Aches
☐ Colds/Flu
☐ Convulsions/Seizures
☐ Delayed Speech
☐ Diabetes
☐ Difficulty Breathing
☐ Difficulty Swallowing
☐ Digestive issues (constipation/diarrhea)
☐ Dizziness
☐ Fainting
☐ Fever (continuous)
☐ Headaches
☐ Heart trouble
☐ Hypertension
☐ Immune system issues
☐ Juvenile Rheumatoid Arthritis
☐ Joint problems
☐ Leg problems
☐ Neck problems
☐ Neurological problems
☐ Orthopedic problems
☐ Paralysis
☐ Poor Appetite
☐ Hernias
☐ Skin Rash
☐ Sinus trouble
☐ Tics
☐ Tonsillitis
☐ Tuberculosis
☐ Walking problems
☐ Weakness
☐ Hearing trouble L R
☐ Ringing in ears L R
☐ Pain in ears L R
☐ Ear discharge L R
☐ Vision trouble L R
☐ Pain in eyes L R
☐ Eye discharge L R

☐ None of the above symptoms apply

Name _____ Date _____ DC/CA_____

PEDIATRIC CONSULTATION NOTES (To be completed by office staff) **FILE #**

TRAUMA HX

MVCs:

Home:

Sports:

Misc:

REVIEW OF SYSTEMS

Neurological:

Musculoskeletal:

Gastrointestinal:

Lymphatic:

Hematological:

Respiratory:

Endocrine:

EENT:

Cardiovascular:

Genitourinary:

LIFE EFFECT

Exercise:

Recreation/Sports:

Relationships:

Sleep:

Self-care:

Energy/Attitude:

School:

Other:

COMPLAINTS

	1°	*2°*	*3°*
Onset			
Aggravating			
Relieving			
Type			
Frequency			
Severity			
Referred			
Associated			