Pediatric Intake Form

Name: _____ **Today's Date:** _____

Nickname: _____ **DOB**:_____ **Phone:** _____

Email: _____ **Mother/Father Names:**_____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Referred by: _____ **Pediatrician:**_____

Has your child been to a chiropractor before? Y N How recently? _____

Reason for consulting us:_____

- If your child has no symptoms or complaints, and is here for wellness services, please check here

If you came in for a specific complaint, please fill out the next portion and briefly describe the issue:
_____

If he/she is experiencing pain, is it (circle all that apply):

Sharp	Shooting
Burning	Aching
Dull	Burning
Comes and goes	Constant

Since the problem started is it: Same Better Getting Worse

What makes it worse?_____

What does it interfere with?_____

Who else have you seen for this issue?_____

Has it helped?_____

List any medications your child is currently taking_____

Past surgeries, traumas or accidents:_____

We often experience physical, chemical and emotional stressors that can accumulate and result in loss of health potential. Often times these effects are gradual and begin very early in life. Please answer the following questions so we can better assess the challenges to your child's health potential.

Pregnancy:

Third trimester presentation: Head down Breech Transverse

Were there any complications during pregnancy?_____

Birth and Delivery:

Where was your baby born? Home Hospital Birthing center

Was the delivery: Vaginal Cesarean Forceps Vacuum/Suction cap

How long was labor?_____ How long was delivery?_____

Was oxytocin/pitocin used? Yes No

Was an epidural used? Yes No

Any congenital anomalies/defects?_____

Infancy:

Was the infant vaccinated? Yes No If yes, alternative schedule? Yes No

Infant feeding: Breast Formula Type:_____

Number of hours of sleep per night?_____ Quality of sleep? Good Fair Poor

Was there any prolonged use of medications or an inhaler? Yes No

If yes, explain:_____

Growth and Development concerns: Sleep patterns, age of head control, smile, sitting standing, walking, teeth, vocalization

_____

Childhood years (1+):

Did the child have any childhood illnesses? Yes No

If yes, explain_____

Does the child play any youth sports? Yes No Which ones?_____

Has the child suffered any traumas, injuries or concussions? Yes No

If yes, explain:_____

Has the child suffered from emotional traumas? Yes No

Please give us any other health information you feel would be helpful:

_____

The statements made on this form are accurate to the best of my knowledge and I request and give consent to Harmony Chiropractic to examine and care for my child.

Guardian's Signature_____

Relationship to child_____ Date signed_____

Informed Consent to Join Manipulation/Mobilization and Care

Dr. April Lundy

1241 Canton St. Suite 100 Roswell, GA 30075

404-400-3332

I hereby request and consent to the performance of joint manipulations/mobilizations and other procedures including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor/s named above and/or other licensed doctor/s who now or in the future treat me while employed by working or associated with serving as back up for the doctor/s or with the doctor/s named above, including those working at the clinic or office listed above.

I have had an opportunity to discuss with the doctor/s named above and/or with other office or clinic personnel the nature and purpose of joint manipulations/mobilization and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, chiropractic and physiotherapy there are some risks to the treatments including but not limited to reactions to modalities, fractures and strains. I do not expect the doctor/s to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/s to exercise judgement during the course of the procedures which the doctor/s feels at the time, based on fact then known, is in my best interests.

I have read, or have read to me above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

_____	_____	_____
Print Patient's Name	Signature	Date
_____	_____	_____
Representative	Relationship	Date

Witness:_____