Family & Sports Chiropractic Group
BLAIR "Taking The Time To Care"
1185 Arthur Street, Eugene, OR 97402, (541) 343 - 7076

PEDIATRIC INTAKE FORM

Name: _____ **Date:** _____

Doctor's Signature: _____

GENERAL INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Gender: _____

Names of Parents/Guardians: _____ Phone #: ( )

Home Address: _____ City, State, Zip: _____

PHYSICIAN INFORMATION

Pediatrician Name: _____

Date of and Reason for MOST RECENT pediatrician appointment: _____

Has your child been to a chiropractor before today? _____ Chiropractor Name: _____

PREGNANCY INFORMATION

Was the pregnancy high risk? _____ If yes, how so? _____

Mom's health history during pregnancy: ☐ nicotine ☐ alcohol ☐ medication ☐ chemical exposure ☐ illness

If you circled any items above, please explain in more detail: _____

BIRTH INFORMATION

Where was your child birthed? _____ Type of Birth: ☐ vaginal ☐ C-section

Birthing Assistance: ☐ induction (pitosin) ☐ epidural ☐ pain medication ☐ forceps ☐ vacuum extraction

Weeks of gestation at birth: _____ Birth Weight: _____ Birth Height: _____ Initial APGAR Score: _____

Were there delivery complications? _____ If yes, please explain. _____

Was your child breastfed? _____ If yes, until what age? _____

PREVIOUS HEALTH HISTORY

Does your child have a disorder/disease? _____ If yes, please explain: _____

Has your child had surgery? _____ If yes, when and for what? _____

Has your child had an X-ray, MRI, or CT scan? _____ If yes, when and for what? _____

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Name: _____ **Date:** _____

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INFANT/TODDLER (0-4 years):

Have you noticed any of the following?:

- ☐ Colic
- ☐ Loss of appetite
- ☐ Trouble sleeping
- ☐ Recurrent ear infections
- ☐ Recurrent colds
- ☐ Asthma/allergies
- ☐ Constipation/Diarrhea
- ☐ Fever
- ☐ Unexpected weight gain or loss

If you are currently breast feeding, do you notice that the child has a preference for a particular breast? _____
If yes, which side does he/she prefer? _____

Please describe any recent trauma (falls, hits on the head, car accidents) that your child has experienced:

_____

_____

At what age was your child able to:

Respond to sound	_____	Sit up	_____
Respond to visual stimuli	_____	Crawl	_____
Hold head up	_____	Walk	_____

CHILD (5-12 years):

Have you noticed any of the following?:

- ☐ Fatigue
- ☐ Bed wetting
- ☐ Scoliosis
- ☐ Fever
- ☐ Asthma/Allergies
- ☐ Headaches
- ☐ Loss of appetite
- ☐ Recurrent illnesses
- ☐ Unexpected weight loss/gain

What symptoms does your child complain of? _____

When did the symptoms begin? _____ Are the symptoms getting better or worse? _____

Are the symptoms constant or intermittent? _____ If intermittent, when? _____

How have the symptoms been affecting your child's activity level? ☐ None ☐ Mildly ☐ Moderately ☐ Severely

Please describe any recent trauma (falls, hits on the head, car accidents) that your child has experienced:

_____

_____

Which sports does your child participates in?

- ☐ Soccer
- ☐ Lacrosse
- ☐ Basketball
- ☐ Karate
- ☐ Swimming
- ☐ Baseball/Softball
- ☐ Volleyball
- ☐ Dance
- ☐ Football/Rugby
- ☐ Gymnastics
- ☐ Wrestling
- ☐ _____

For female patients:

Has your child had her first period? _____ If yes, at what age? _____