BLOSSOM
FAMILY CHIROPRACTIC

Pediatric Intake Form

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ M.I.:_____ Last Name:_____

Preferred Name: _____

Address:_____

City / State / Zip: _____

Birth Date: _____ Age:_____ Sex:O MO F

# of Siblings:_____ Sibling's Names & Ages: _____

_____

Parents Names _____

Best Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Parent's Email: _____

Who can we thank for referring you or how did you hear about our office?_____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Blossom Family Chiropractic:_____

_____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your child's life? _____

_____

Has your child seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? ☐ Yes ☐ No

How long ago?_____ Clinic/Doctor Name: _____

What is your reason for the change? (if applicable) _____

What is your level of commitment to yourself and your child's health 1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

Print Patient's Name: _____ Date: _____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain/Stiffness
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Explain any boxes checked above:

_____

_____

_____

_____

_____

Is there anything else regarding your child's condition you feel the doctor should know? _____

_____

_____

_____

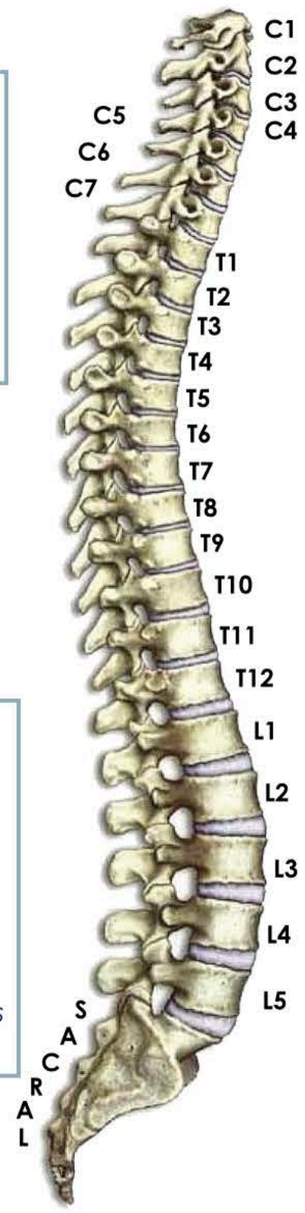
_____

_____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions



Headaches
Mirgrains
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Fish Oil/Omega-3
- ☐ Vitamin D3
- ☐ Probiotics
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Explain any boxes checked above:

_____

_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

_____

_____

_____

Print Patient's Name: _____ Date: _____

PRENATAL HISTORY

Location of birth: ◯ Home ◯ Birthing Center ◯ Hospital ◯ Other: _____

Did any of the following happen during delivery:

◯ C-section delivery ◯ Doctor pulled or twisted baby ◯ Anesthesia ◯ Labor was induced

◯ Forceps/vacuum extraction ◯ Premature delivery ◯ Special medical procedures/test

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

_____

Did you experience any illness while pregnant? ◯ Yes ◯ No If yes, explain: _____

Do you have any physical disabilities? ◯ Yes ◯ No If yes, explain: _____

Birth weight: _____ Birth Length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? ◯ Yes ◯ No Number of times: _____

Did you breastfeed the baby? ◯ Yes ◯ No If yes, how long: _____

Did you formula-feed the baby? ◯ Yes ◯ No If yes, how long: _____

At what age did you introduce: Solids:_____ Cow's milk:_____

LIFESTYLE HABITS

Does your child exercise daily? ◯ Yes ◯ No How much? _____

Does your child drink soda? ◯ Yes ◯ No How much/often? _____

Does your child have positive self-esteem or self-image? ◯ Yes ◯ No _____

Does your child watch more than an hour of TV per day? ◯ Yes ◯ No How much? _____

Does your child eat balanced meals? ◯ Yes ◯ No

Does your child experience prolonged sadness? ◯ Yes ◯ No Explain: _____

Does your child have difficulty sleeping? ◯ Yes ◯ No Explain: _____

Does your child play video games? ◯ Yes ◯ No How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? ◯ Yes ◯ No Explain: _____

Has your child ever been hospitalized or had surgery? ◯ Yes ◯ No Explain: _____

Does your child have difficulty interacting with others? ◯ Yes ◯ No Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ◯ Yes ◯ No Explain:

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.) ◯ Yes ◯ No

Please list: _____

Are you aware of any food allergies or intolerance? ◯ Yes ◯ No Explain: _____

Has your child received vaccinations? ◯ Yes ◯ No ◯ All Vaccines ◯ Alternative ◯ None

Please rate stress levels on a scale of 1 - 10 (10 = highest)

School: ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 Personal: ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Blossom Family Chiropractic permission to exam, x-ray (if necessary), and treat_____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

Print Patient's Name: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Savy Ford and staff who now or in the future treat my child while employed by this office. I will have an opportunity to discuss with Blossom Family Chiropractic personnel and nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Blossom Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Blossom Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions abzout its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

Parent/Guardian Signature:_____ Date: _____

Witness: _____ Date: _____