Restoration Health Chiropractic
Pediatric Intake Form

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ABOUT YOU

First Name:	Middle Name:	Last Name:
Street Address:		
Address Line 2:		
City:	State:	Zip:
Mobile Phone:	Work Phone:	Home Phone:
Home Email Address:		Date of Birth:
Gender:	Height:	Weight:
Name of Parents/ Guardians:		
Number of Children:		

PURPOSE OF VISIT

Purpose for this visit? _____

Other Doctors Seen for this Condition: _____N _____ Y

Doctor(s) name and prior Treatments: _____

_____

_____

Other Health Problems?_____

_____

Check any of the following conditions that your child has suffered from during the past six (6) months:

Ear Infections ☐ Headaches ☐ Colic ☐ Chronic Colds ☐ Recurring Fevers ☐ Car Accident ☐

Asthma/ Allergies ☐ Growing/ Back Pains ☐ Temper Tantrums ☐ Scoliosis ☐

Digestive Problems ☐ Car Accident ☐ Seizures ☐ ADHD ☐ Bed Wetting ☐ Other ☐

_____

PERTINENT HISTORY

Previous Chiropractor? _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason _____

Number of doses of antibiotics your child has taken - during the last six months:_____ In his/her lifetime: _____

Vaccine History: _____

Complications/Medication Usage/Alcohol or Cigarettes during Pregnancy or Delivery? _____

_____

_____

Birth Location? Home Birth?_____

DEVELOPMENTAL HISTORY

Has your child been involved in high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? No ☐ Yes ☐ List: _____

Has your child been involved in a Car Accident? No ☐ Yes ☐ List:

_____

Has your child been seen on an Emergency basis? No ☐ Yes ☐ List:

_____

Other traumas not described above? No ☐ Yes ☐ List: _____

What improves this condition or gives you relief?

Have other health care provider(s) performed tests related to this condition?

Have you ever had any previous episodes of this condition?

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? O No O Yes Explain:

Are there any past illnesses or conditions we should be aware of?

O No O Yes Explain:

Do you have a past history of accidents or trauma?

O No O Yes Explain:

Is your child presently taking any medications? O No O Yes Explain:

Do you have a past family illness history such as diabetes, cancer, hypertension, or progressive neurological diseases that we should be aware of? O No O Yes Explain:

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient/Parent Signature: _	Date: