PEDIATRIC INTAKE FORM
MOMENTUM CHIROPRACTIC

Please Fill Out Form Completely, If a Question Does Not Apply, Mark N/A

Today's Date: _____

CHILD'S PATIENT INFORMATION

Name: _____ Parent/Guardian Name(s): _____

Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Last 4 digits of S.S. #: _____

Name & Number of Emergency Contact: _____ Relationship: _____

How did you hear about our office?

☐Google ☐Facebook ☐Instagram ☐Nextdoor

☐Referral (please name) _____ ☐Our website

CURRENT HEALTH CONDITIONS

Please list the condition(s) that brought your child into the office: _____

When did the problem(s) start? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Have you seen anyone else for these condition(s) in the past? ☐No ☐ Yes **If yes,** when: _____

by whom? _____

How long was your child under care: _____ What were the results?

_____

Has your child ever been to a Chiropractor? _____ ☐ **yes (who?)** ☐ **no**

Is the child currently taking any medications, herbs, vitamins, or supplements? (if so, please list)

_____

HEALTH GOALS

What are your top 3 health goals for your child?

1. _____
2. _____
3. _____

PREGNANCY AND FERTILITY HISTORY

Any fertility issues? ☐yes ☐no If yes, please explain:

Did the mother smoke? ☐yes ☐no If yes, how many per week?

Did the mother drink? ☐yes ☐no If yes, how many per week?

Did the mother exercise? ☐yes ☐no If yes, please describe the exercise

Please explain any episodes of mental or physical stress during the pregnancy:

_____

LABOR AND DELIVERY HISTORY

Child's birth was: ☐Natural, vaginal birth ☐Scheduled C-section ☐Emergency C-section

Child's birth was: ☐ At home ☐At a birthing center ☐Hospital ☐Other

Doctor/Obstetrician's name: _____

Please check any applicable interventions or complications:

☐Breech ☐induction ☐Pain medication ☐Epidural ☐Vacuum extraction ☐Forceps

☐Other

Child's birth weight: _____

Child's birth height: _____

APGAR score at birth: _____

Any other information about the birth we should be aware of? _____

Was the child involved in an accident or trauma prior to coming into the office? ☐ Yes, ☐ No
If Yes, briefly describe the incident: _____

Identify any injury(s) to areas of the spine, surgical or non-surgical, that our office should be aware of:

_____

_____

PAST HISTORY

Has your child suffered with this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury occur? _____

Have you tried other treatment options?: ☐ No ☐ Yes **If yes,** please state **what** type of treatment **and** the provider:

_____

How long ago? _____What were the results? ☐ Resolved ☐ Unresolved ☐ Unable to determine

Please list any hospitalizations and surgeries your child has had (including the year):

_____

Has your child ever had difficulty sleeping? ☐yes ☐no

How would you describe your child's diet? ☐whole,organic foods ☐Average ☐high amount of processed foods

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? (if so, please list)

VERIFICATION QUESTION (*please circle the question you've chosen and provide the answer. This will further protect your files within our clinic)*

☐What is your mother's maiden name?
☐What elementary school did you attend?
☐What is your favorite movie?
☐What is your favorite place you've visited?
☐What city were you born in?
☐What is your father's middle name?

Answer to verification question: _____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Momentum Chiropractic LLC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Momentum Chiropractic LLC for any and all services I receive at this office.

_____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed

_____
Doctor's Signature

_____ - _____ - _____
Date Form Approved For Care