Pediatric Intake Form

Date: ______________________

Child's Name: ______________________ DOB: ______________________

Parent / Guardian's Name: ______________________

Home Phone #: ______________________ Cell Phone #: ______________________

Address: ______________________

E-mail Address: ______________________

Will you be using any insurance? Yes No

How did you hear about Neuroedge Chiropractic? ______________________

Has your child been checked by a Doctor of Chiropractic? Yes No

Were x-rays taken? Yes or No

Who is your medical pediatrician? ______________________

Prenatal History:

Did you have any complications and when? ______________________

Is your child adopted? Yes No

Did you smoke? Yes No

Did you consume alcohol? Yes No

Did you take medication? Yes No

Reason for the medication? ______________________

Describe your typical diet:

Birth History:

Did you have ultrasound during this pregnancy?

What was the frequency? __________

Place of Birth:	Home	Birthing Center	Hospital
Provider:	Midwife	OB-Gyn	Other
Type of Birth:	Vaginal	C-section VBAC	
Were pain medications (Epidural) used?		Yes	No
Was labor induced?		Yes	No
If yes, why? ______________________			
What position did you deliver in?	Squatting	On back	Other

Birth Trauma?

Doctor assisted Twisting and/or Pulling Vacuum Extraction Forceps

Newborn trauma (medical procedures and tests):

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Child (5-12 years):
Have any of the following occurred?

Back or Neck Pain	Fall off of a bicycle	Sports accident	Car accident
Stomach pains	Scoliosis	Bed wetting	Fall on playground
ADHD / Autism	Learning/reading difficulties	Asthma	Allergies
Leg / Knee pains	Other (Please explain): ______		

Does your child participate in any of the following?

Hockey	Football	Gymnastics	Karate
Wrestling	Lacrosse	Basketball	Dance
Volleyball	Tennis	Other:______	

How does his/her condition effect his/her activities? Can't Participate Somewhat hindered Not At All

Please describe his/her typical diet:

Number of hours your child sleeps? ____hours

Sleep Quality? Good Fair Poor

Number of hours in front of a screen (Tablet, TV, Computer):

Please describe any other concerns or conditions not covered above:

Office Policies & Procedures

________1. **Symptoms:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

________2. **Appointments**: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness and avoid being charged a $20 fee. It is your responsibility to get here. We will do all we can to accommodate you.

________3. **Dynamic Examinations**: During your Initial Intensive Care you will receive several Dynamic Examinations to monitor your level of spinal correction. On this visit, you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending approximately 30 extra minutes on these days. Immediately following your Dynamic Examination, the doctor will sit down with you to discuss your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

________4. **Exercise:** Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, disks, and nerves. However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced. We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

________5. **Nutrition**: Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs on a daily basis.

________6. **Results:** We are very results oriented, however many factors that we have no control over affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

PATIENT: ________________________ DATE: _______________

WITNESS: ________________________

Congratulations on choosing Chiropractic. Follow through with your family, and enjoy the health benefits that come with a Chiropractic lifestyle.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic 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 or intern, affiliated with Neuroedge Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Neuroedge Chiropractic to perform such. 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.

______________________________ ____________________

Patient's Name (Please Print) Date

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Patient or Guardian's Signature

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Did your child have a misshaped skull / head? Yes No

Were there purple markings on their face? Yes No

Did you breast feed your child? Yes No

Does your child prefer one breast over the other? Yes No

If yes, which side Right Left

Does your child have any food allergies? Yes No

If yes, please list: ______________________________

Has your child been vaccinated? Yes No

Did your child have any negative reaction to the vaccinations? Yes No

Has your child ever had any surgeries? Yes No

If yes, please elaborate. ______________________________

Has your child been on antibiotics? Yes No

If yes, how often and what for? ______________________________

Is your child currently taking any medication? Yes No

Is your child currently taking any vitamins? Yes No

Baby / Toddler (0-4 years):
Have any of the following occurred?

Fell out of crib	Fell off of playground equipment	Plays in a Johnny Jumper	Frequent ear infections
Tonsillitis	Reaction to vaccines	Frequent fevers	Frequent diarrhea
Constipation	Sleeping problems	Repeated infections or colds	Colic
Fall from a changing table	Frequent crying spells	Tumble down stairs	Involvement in MVA
Toe walking	Difficulty crawling or skipped crawling	Speech Impairment	Only eat certain foods

Other (Please explain): ______________________________