

NOYA CHIROPRACTIC PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____

Sex M F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

HOW CAN WE HELP YOUR CHILD?

Wellness Checkup Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? Yes No

Please describe: _____

BIRTH HISTORY

Type of birth (check all that apply):

Hospital Birth Center Home Normal / Vaginal Breech
 Cesarean Scheduled/Induced Epidural

Problems during labor / delivery? _____

Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
 Respiratory Distress Extended Hospitalization Other _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

Back/Other Pain Gestational Diabetes Pre/Eclampsia Strep B Nausea/Vomiting
 Pre-Term Fatigue Swelling Other (please describe) _____

GROWTH & DEVELOPMENT

Infant feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child: _____

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox Measles Rubella
 Mumps Rubella Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Digestive Issues
(constipation/diarrhea) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Ear Aches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Juvenile
Rheumatoid Arthritis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Back Aches | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Delayed Speech | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes | | | <input type="checkbox"/> Walking Problems |

Have you vaccinated your child?

- No Yes As scheduled Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____

Number of pregnancies: _____

Children's' Ages: _____

Are you currently pregnant? No Yes, I'm due: _____

Childrens' health concerns: _____

Health concerns regarding this pregnancy? _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Date: _____