

Gard Wellness Center

Pediatric Intake Form for ages 0-12 years old

Patient Information:

Date: _____
Child's Name: _____ DOB: _____
Parent / Guardian's Name: _____
Home Phone #: _____ Cell Phone #: _____
Address: _____
E-mail Address: _____
Has your child been checked by a Doctor of Chiropractic? Yes No
If yes, please provide the name of the office & doctor. _____
Were x-rays taken Yes No
Who is your medical pediatrician? _____

Prenatal History:

Is your child adopted? Yes No
Did you have any complications and when? _____
Did you smoke? Yes No
Did you consume alcohol? Yes No
Did you take medication? Yes No
Reason for the medication? _____

Birth History:

Did you have ultrasound during this pregnancy? Yes No
What was the frequency? _____
Place of Birth: Home Birthing Center Hospital
Provider: Midwife OB-Gyn Other
Type of Birth: Vaginal C-section
Were pain medications 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):
APGAR score: birth ____/10 5-minutes ____/10 Unsure
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 immunized? Yes No
Reason for vaccination? Informed decision Recommended Didn't know I had a choice.
Did your child have any negative reaction to the vaccinations? Yes No
Were they reported? 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):

Have any of the following occurred?

- | | | | |
|----------------------------|----------------------------------|------------------------------|-------------------------|
| Fall from a changing table | Frequent crying spells | Tumble down stairs | Involvement in MVA |
| Fall out of crib | Fall off of playground equipment | Play in a Johnny Jumper | Frequent ear infections |
| Tonsillitis | Reaction to vaccines | Frequent fevers | Frequent diarrhea |
| Constipation | Sleeping problems | Repeated infections or colds | Colic |
| (+ or -) weight gain | Other (Please explain): _____ | | |

Child (5-12):

Have any of the following occurred?

- | | | | |
|------------------------|-------------------------------|-----------------|--------------------|
| Fall from a tree | Fall off of a bicycle | Sports accident | Car accident |
| Stomach pains | Scoliosis | Bed wetting | Fall on playground |
| Hyperactivity / Autism | Learning difficulties | Asthma | Allergies |
| Leg / Knee pains | Other (Please explain): _____ | | |

Which of the above bothers your child the most? _____

When did it begin? _____

Is it getting worse? _____

- | | | | | |
|--|---------------------|------------|-------|--------|
| Is the pain: | Constant | Intermit | Yes | No |
| Affect on activity? | Not at all | Somewhat | | Cyclic |
| Does your child participate in any of the following? | | | | Always |
| Soccer | Football | Gymnastics | | Karate |
| Hockey | Lacrosse | Basketball | | Dance |
| Wrestling | Baseball / Softball | Volleyball | | Tennis |
| Swimming | Rugby | Other | _____ | |

- | | | | |
|--|---------------|---------------------|------------------------------|
| How would you rate your child's diet? | Well balanced | Average | High sugar / processed foods |
| Does your child consume artificial sweeteners? | | Yes | No |
| Fluoridated water? | | Yes | No |
| Number of hours your child sleeps? | | _____ hours per day | |
| Sleep Quality? | Good | Fair | Poor |

Authorization to treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize the chiropractic physicians at Gard Wellness Center and whomever they may designate as assistant to perform in judgment any examination and chiropractic diagnosis and treatment which is deemed necessary.

Any specific written authorization you may provide may be revoked at any time by writing to us at the address listed on our website, www.gardwellness.com

Signature _____

Date _____