

Hoffman Chiropractic
Pediatric Intake Form (Birth to Age 6)
(To be completed by the parent or legal guardian)

PATIENT NAME _____ DATE _____

ADDRESS _____

PURPOSE OF THIS VISIT _____

MOTHER'S NAME _____ PHONE (H) _____ (W) _____

EMPLOYER _____ OCCUPATION _____

FATHER'S NAME _____ PHONE (H) _____ (W) _____

EMPLOYER _____ OCCUPATION _____

LEGAL GUARDIAN _____ RELATIONSHIP TO PATIENT _____

AGE (MOS) _____ (YRS) _____ DATE OF BIRTH ____ - ____ - ____ SEX _____ # OF SIBLINGS _____

BIRTH WEIGHT _____ PRESENT WEIGHT _____

BIRTH HEIGHT _____ PRESENT HEIGHT _____

WAS THE BIRTH: ___ NORMAL VAGINAL ___ VACUUM EXTRACTION
 ___ CESAREAN ___ FORCEPS
 ___ BREECH

LOCATION OF BIRTH: HOSPITAL _____
 BIRTHING CENTER _____
 HOME BIRTH _____

PREGNANCY PROBLEMS _____

LABOR OR DELIVERY PROBLEMS _____ APGAR _____

CONGENITAL DEFECTS/ANOMALIES _____

WAS THERE PRESENCE AT BIRTH: ___ MECONIUM ___ CYANOSIS(blue) ___ JAUNDICE(yellow)

OBSTETRICIAN / MIDWIFE _____ ADDRESS _____

PEDIATRICIAN _____ ADDRESS _____

IMMUNIZATION DATES: HEP B _____ DTAP _____
 IPV _____ HIB _____
 MMR _____ VAR _____
 FLU _____ HEP A _____

ADVERSE REACTIONS: _____

DATE AND PURPOSE FOR LAST MD VISIT _____

HAS THIS CHILD BEEN TREATED FOR ANY EMERGENCY? _____
DESCRIBE _____

SURGERIES? _____

ACCIDENTS? _____

CURRENT MEDICATIONS _____

LIST ALL ANTIBIOTICS _____

HAS THIS CHILD EVER SUFFERED FROM:

- | | |
|--|--|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> HEART PROBLEMS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HYPERACTIVITY |
| <input type="checkbox"/> ARM PROBLEMS | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> JOINT PROBLEMS |
| <input type="checkbox"/> BACKACHES | <input type="checkbox"/> LEG PROBLEMS |
| <input type="checkbox"/> BED WETTING | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> BEHAVIORAL PROBLEMS | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> MUSCLE PROBLEMS |
| <input type="checkbox"/> CHICKENPOX | <input type="checkbox"/> NECK PROBLEMS |
| <input type="checkbox"/> CHRONIC EARACHES | <input type="checkbox"/> NEURITIS |
| <input type="checkbox"/> COLDS/FLU | <input type="checkbox"/> ORTHOPEDIC PROBLEMS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> PARALYSIS |
| <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> POOR APPETITE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> PNEUMATIC FEVER |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> RUPTURES/HERNIAS |
| <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> SUGAR LEVELS |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> GROWING PAINS | <input type="checkbox"/> WALKING PROBLEMS |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> WHOOPING COUGH |

TYPE OF DIET _____

ENVIRONMENTAL FACTORS _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THIS CHILD?

I CERTIFY THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

OFFICE USE:

PATIENT NAME _____ FILE NUMBER _____
DOCTOR OF RECORD _____

