Child Intake Form

Thank you for choosing LifeHouse Chiropractic. We are committed to providing you and your family with chiropractic care.

Please complete this intake form fully and accurately. The more we know about your child and their health concerns, the better we can help. If you have any questions, ask any of our trained staff members or wait and ask the doctor.

Goals for my Child's Care

Children see chiropractors for a variety of reasons. Please check the type of care desired so that we can understand your health goals and serve you the best way possible.

- ☐ Relief Care – symptomatic relief of pain or discomfort
- ☐ Corrective Care – correcting and relieving the cause of the problem as well as the symptoms
- ☐ Comprehensive Care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments
- ☐ Wellness Care - my child has no symptoms but I understand the benefits of having a properly functioning nervous system
- ☐ I want the Doctor to select the type of care appropriate to my child's health status.

.....

(Signature) (Date)

Your Child's Information

Child's Name _____

Birthdate_____ Age_____

Height_____ Weight_____

Gender: ☐ Male ☐ Female Number of Siblings:_____

Names of Parents/Guardians:_____

Street Address _____ Unit #_____

City _____ Prov _____ Postal _____

Parent's Telephone

Home_____ Cell_____

Work_____ Work Extension_____

Parent's Email_____

Parent's Occupation _____

Experience with Chiropractic Care

Who referred your child to this office?_____

Has your child ever been adjusted by another Chiropractor?
☐ *Yes* ☐ *No*

Reasons for those visits?

_____

Were X-rays taken? ☐ *Yes* ☐ *No*

Did your family receive chiropractic care? ☐ *Yes* ☐ *No*

Chiropractor's Name: _____

Approximate date of last visit: _____

What is the purpose of this appointment?

Describe the purpose of this visit

_____

_____

(for a specific chief complaint, please complete the section immediately below)

When did your child's condition begin?

_____

How did it happen?

_____

What makes your child's condition feel better?

_____

What activities aggravate you child's condition?

_____

Has this condition?

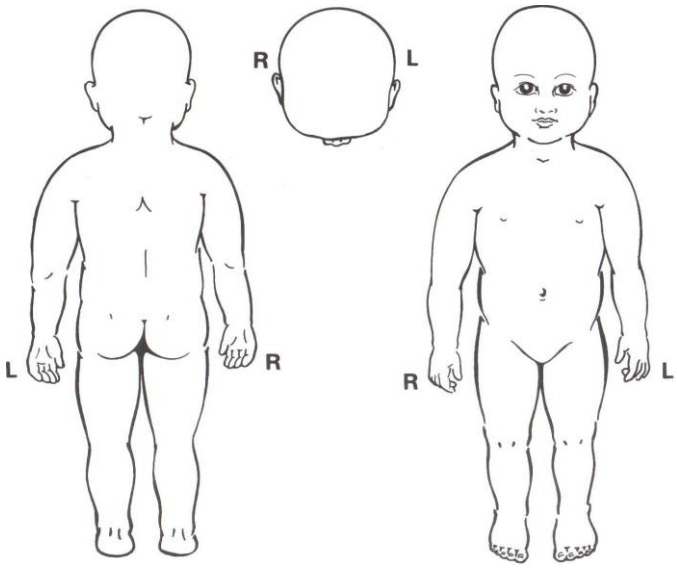
☐ *worsened* ☐ *constant* ☐ *comes and goes*

Does this condition interfere with?

☐ *Sleeping* ☐ *Feeding* ☐ *Dressing* ☐ *School*

☐ *Sports* ☐ *Playing* ☐ *Communication* ☐ *Walking* ☐ *Attention* ☐ *Other Activities* (explain below)

_____



Please indicate (with an "x") the areas of your child's complaint on the diagram above.

Has your child seen any other health care providers for management of this condition? ☐ *Yes* ☐ *No (If yes, explain)*

_____

Name of pediatrician: _____

Is it ok if we send him/her updates on your child's care? ☐ Yes ☐ No

Please check each that your child has now or has had in the past. While some conditions may seem unrelated, they can affect diagnosis, the care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

☐ ADD/ADHD
☐ Allergies
☐ Asthma
☐ Autism
☐ Back problems
☐ Bed wetting
☐ Chronic colds
☐ Chronic cough
☐ Colic
☐ Constipation
☐ Crossed Eyes
☐ Crying (frequent)
☐ Deafness
☐ Diarrhea (frequent)
☐ Digestive Problems
☐ Dizziness
☐ Ear Infections
☐ Fatigue
☐ Fever (frequent)
☐ Headaches
☐ Irregular breathing
☐ Nasal blockage
☐ Reflux
☐ Scoliosis
☐ Seizures
☐ Sinus problems
☐ Skin issues/eczema
☐ Sleep problems
☐ Torticollis
☐ Vision problems
☐ Weight gain
☐ Weight loss

Other:_____

Is/was your child:
☐ Breast fed
☐ Formula fed
Brand: _____

Does/did your child use a soother?
☐ Yes
☐ No

How many hours of tummy time did/does get your child per day?
_____

Did/does your child use a jolly jumper/bumbo?
☐ Yes ☐ No

How many diapers do/did you change per day?_____

Sources of Spinal Stress

Used to help us determine the cause of your child's problem.

General Physical Trauma

Falls (Details and Dates)

- ☐ Fall from a crib _____
- ☐ Fall from a high chair _____
- ☐ Fall from a bed/ couch_____
- ☐ Fall off a swing _____
- ☐ Fall off slide _____
- ☐ Fall downstairs_____
- ☐ Fall off a bicycle_____
- ☐ other _____

Other Injuries (Details and Dates)

- ☐ Playing Sports _____
- ☐ Injuries at school _____
- ☐ Car accident_____
- ☐ other_____

Birth History

Prenatal Care

Was the mother under chiropractic care during her pregnancy? ☐ *Yes* ☐ *No (if yes, explain)*

_____

Did the mother experience any complications during her pregnancy? ☐*Yes* ☐ *No (if yes, explain)*

_____

Did the mother get any ultrasounds during her pregnancy? ☐*Yes* ☐ *No (if yes, how many)*

_____

Did the mother sustain any falls, accidents, or injuries during pregnancy?
☐ *Yes* ☐ *No* ☐ *Unknown*

_____

Were any of the following used during the pregnancy?

- ☐ Medications *(please list)*_____
  _____
- ☐ Caffeine
- ☐ Cigarettes
- ☐ Alcohol
- ☐ Prenatal Vitamins

Other_____

Child's Birth

With respect to your child's birth process, please check all that apply:

- ☐ Natural
- ☐ Premature
- ☐ Breech
- ☐ Forceps / Vacuum Extraction
- ☐ Epidural / Drug Induced
- ☐ C-Section
- ☐ Prolonged delivery
- ☐ Pulling/twisting by doctor
- ☐ Cord around neck

Conditions experienced immediately following birth:

- ☐ Jaundice
- ☐ Feeding problems
- ☐ Respiratory problems
- ☐ Fracture
- ☐ Other: _____

Birth Location:

- ☐ Home
- ☐ Hospital
- ☐ Other: _____

How long did the birth last?_____

APGAR score: 1-minute:_____ 5-minute:_____

How would you describe the birth experience?

- ☐ Terrific
- ☐ Just ok
- ☐ Traumatic

Any genetic disorders or disabilities?
☐ *Yes* ☐ *No (if yes, explain)*

_____

Miscellaneous

If answering yes to any questions below, please list dates and details where applicable.

Has your child ever been knocked unconscious?
☐ *Yes* ☐ *No (if yes, explain)*

_____

Has your child ever had a surgical operation?
☐ *Yes* ☐ *No (if yes, explain)*

_____

Has your child ever been hospitalized for any other reason?
☐ *Yes* ☐ *No (if yes, explain)*

_____

Family Health History

Family members diagnosed with health problems:

_____
_____
_____

History of Chemical Stress

Medication history:

Prescription medication history:

How many in the past year_____

Type_____

Reason_____

Over the counter medication history:

How many in the past year:

_____

Type: _____

Reason: _____

_____

Vaccination history:

My child was:

☐ Fully vaccinated on a regular schedule
☐ Fully vaccinated on a delayed schedule
☐ Partially vaccinated:
Explain:

_____

☐ Undecided:_____

Smoking History:

Is your child exposed to second hand smoke? ☐ *Yes* ☐ *No*

Developmental Milestones

Please check off all milestones that your child has met and indicate if they were delayed.

1-2 months

☐ Holds head up
☐ delayed
☐ Turns head and eyes to sound
☐ delayed
☐ Follows objects through visual field
☐ delayed
☐ Alert in response to voices
☐ delayed
☐ Recognizes parents
☐ delayed
☐ Brings hand to mouth
☐ delayed
☐ Engages in vocalization (coos)
☐ delayed

Describe any difficulties: _____

_____

_____

3-5 months

☐ Smiles
☐ delayed
☐ Holds head up/raises body with hands
☐ delayed
☐ Reaches for things/brings to mouth
☐ delayed
☐ Sits with support (head steady)
☐ delayed
☐ Rolls from front to back
☐ delayed
☐ Pushes with legs when feet are placed on hard suface
☐delayed
☐ Squeals
☐ delayed
☐ Consontants: m,b,p / vowels: o,u
☐ delayed

Describe any difficulties: _____

_____

_____

6-8 months

☐ Some weight bearing
☐ delayed
☐ Imitates bye-bye
☐ delayed
☐ Sits alone for a short time
☐ delayed
☐ Rolls from front to back/back to front
☐ delayed
☐ Babbles and imitates speech
☐ delayed

Describe any difficulties: _____

_____

_____

Please check off all milestones that your child has met and indicate if they were delayed.

9-11 months

☐ Sits alone
☐ delayed
☐ Crawls
☐ delayed
☐ Pulls to stand
☐ delayed
☐ Stands alone
☐ delayed
☐ Walks supported by furniture
☐ delayed
☐ Uses thumb & index finger to pick up small objects
☐ delayed
☐ Feeds self
☐ delayed

Describe any difficulties: _____

_____

_____

12 months

☐ Walks with support or independently
☐ delayed
☐ Gives toys upon request
☐ delayed
☐ Points to desired objects
☐ delayed
☐ Looks for hidden objects
☐ delayed
☐ Says mama/dada
☐ delayed

Describe any difficulties: _____

_____

_____

24 months

☐ Runs
☐ delayed
☐ Holds cup securely
☐ delayed
☐ Stands on one foot
☐ delayed
☐ Ascends and descends stairs
☐ delayed
☐ Jumps on floor with both feet
☐ delayed
☐ Verbalizes toilet needs
☐ delayed

36 months

☐ Speaks with 2-3 sentences
☐ delayed
☐ Completely toilet trained during day
☐ delayed

Describe any difficulties: _____

_____

_____