

Pediatric Intake Form

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Child's Name _____ Date of Birth _____
Parent's Names: Mother _____ Father _____
Address _____
City _____ State _____ Zip _____
Phone # _____

1. Is your child currently benefiting from Chiropractic care Y / N Last Visit _____

2. Please Circle Appropriately: Birth Place: Home / Hospital / Birth Center
Type: Vaginal/ C-section
Procedures: Forceps/ Vacuum Extraction

3. Please list all sports and activities that your child participates in: _____

Please list any known injuries: _____

4. According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, Changing table, etc) during the first year of life. Has this happened to your child? Y/N

If yes, please explain: _____

5. Please circle any of the following conditions the your child has suffered from in the last 12 months

Ear Infection	Scoliosis	Chronic Colds	Head Aches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers
Colic	Bed Wetting	Growing Pains	
Seizures	Car Accident	Other _____	

6. In the last year has your child taken or is your child currently taking any prescription or over the counter medications? Y/N

If yes please list the name of the medication and the reason for its use: _____

7. Has your child been fully vaccinated? Y/N

8. Has your child experienced any adverse reactions to the vaccines? Y/N

Please list all reactions your child experienced: _____

9. Please list any and all concerns you have about your child's health that that have not been addressed yet.

10. Parental Consent: I, _____, give permission for my child, _____, to be examined by Body In Balance Wellness Center.

Signature: _____ Date _____