Pediatric Chiropractic Intake Form

Dr. Elizabeth Crumbaugh DC

Patient (Child) Information:

Name: ____ Date: _________________________________

Address: ____

Sex: Male Female Date of Birth: _______________ Height:_________________ Weight: _______________

Patient SSN: __________________________________ Name of Parents/Guardian:______________________________

Home Phone:______________________ Cell Phone: _______________________ Work Phone: ______________________

Email:____ Would you like our newsletter emailed to you: Y N

Whom may we thank for referring you? ____

Authorized Representative/Parent/Guardian:__________________________________ Phone: ______________________

Present Complaint: ____

When did this begin?_______________________________________ Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N Describe: ____

Current medications: _______________________________________

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain: ____

Medications taken during pregnancy: ___________________________ Cigarettes or alcohol during pregnancy: Y N

Birth Intervention: Forceps Vacuum C-Section

Complications during delivery? Y N Explain: ____

Genetic disorders or disabilities:____

How many times has your child been prescribed antibiotics in the past 6 months? _______ Total during lifetime:______

Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long: ___________

Formula Fed: Y N How long: ___________

Introduced to: Solids at _______ Months

Cows milk at ________ Months

Food Allergies or Intolerances: Y N

List:__________________________________

Childhood Diseases:

Chicken Pox: Y N Age:______________

Rubella: Y N Age:______________

Rubeola: Y N Age:______________

Mumps: Y N Age:______________

Whooping Cough: Y N Age:______________

Other: ________________ Age:______________

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_______________ Respond to Sound

_______________ Respond to Visual Stimuli

_______________ Hold Head Up Alone

_______________ Sit Up Alone

_______________ Cross Crawl

_______________ Stand Alone

_______________ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N

Explain: ____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

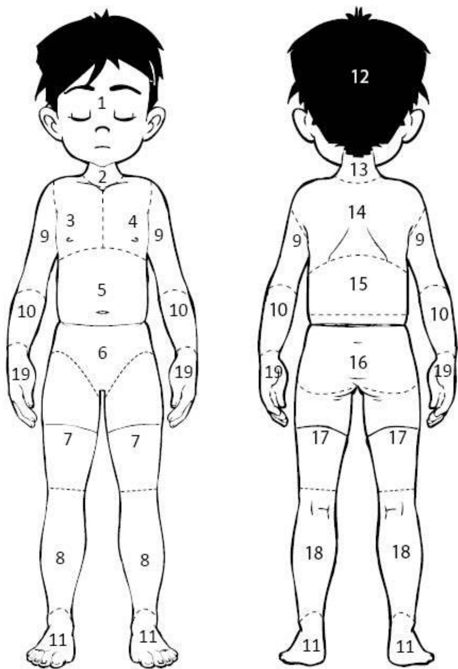
Has your child ever been involved in a car accident? Y N Explain:____
Other traumas not described above? Y N Explain:____
Prior surgeries? Y N Explain:____

Review of Systems

Please check if your child has had any of the following:

____ Headaches	____ Postural Imbalances	____ Growing Pains	____ Scoliosis	____ Tonsillits
____ Asthma	____ Torticollis	____ Ear Infections	____ Seizures	____ Sleep Problems
____ Digestive Problems	____ Bedwetting	____ PDD/Autism	____ ADD/ADHD	____ Frequent Fever
____ Colic	____Learning Difficulties	____ Acid Reflux	____ Hip Dysplasia	____ Allergies

How would you rate your child's diet? ____ Well Balanced ____ Average ____High sugar/processed foods
Does your child consume artificial sweeteners? Y N
Number of hours your child sleeps:____________________ hours per night ________________hours per day/naps
Sleep Quality: ____Good ____Fair ____Poor



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Authorization to Treat a Minor

I, ____________________________________ the undersigning parent/guardian having legal custody/guardianship of ______________________________________, a minor, do hereby authorize, request and direct Dr. DeCamp and whomever she might designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: ____ Signature: ____
Print Name Parent/Legal Guardian