

# PEDIATRIC INTAKE FORM -

TRUE HEALTH CHIROPRACTIC

Date: \_\_\_\_\_ Account # \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Primary reason for consulting our office: \_\_\_\_\_  
\_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Satisfied with the care you received? Y\_\_\_ N\_\_\_

## PRENATAL HISTORY:

List any problems during pregnancy: \_\_\_\_\_  
List any complications during delivery: \_\_\_\_\_  
Did mother have Ultrasound during pregnancy? Y\_\_\_ N\_\_\_  
Did mother use any medication during pregnancy? Y\_\_\_ N\_\_\_  
Location of birth: Hospital\_\_\_ Home\_\_\_ Birthing Center\_\_\_

## FEEDING HISTORY:

Breast Feed? Y\_\_\_ N\_\_\_ If yes, how long? \_\_\_\_\_  
Formula? Y\_\_\_ N\_\_\_ If yes, how long? \_\_\_\_\_  
Nurse as well on the left side as the right side? \_\_\_\_\_  
Food allergies of intolerance? \_\_\_\_\_

## DEVELOPMENTAL HISTORY:

Age child responded to: Sound\_\_\_ Visual\_\_\_ Hold head up\_\_\_ Crawling\_\_\_  
Sit up\_\_\_ Standing\_\_\_ Walking\_\_\_  
Any falls and at what age? \_\_\_\_\_  
Participate in any sports? \_\_\_\_\_  
Accidents? \_\_\_\_\_  
Child ever seen on an emergency basis? \_\_\_\_\_  
Surgeries? \_\_\_\_\_

## MEDICATIONS:

Number of doses of antibiotics: Past six months: \_\_\_\_\_ Total Lifetime: \_\_\_\_\_  
Other medications: Past six months: \_\_\_\_\_  
Lifetime: \_\_\_\_\_  
Immunization History: \_\_\_\_\_  
ANY Vaccine Reactions: \_\_\_\_\_