

# PEDIATRIC INTAKE FORM (3- 10 YEARS )

Name (first, middle,last) \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_ Have  
you ever had chiropractic care before? **Y N** Name of last chiropractor \_\_\_\_\_

## REASON FOR VISIT

### Please circle all that apply:

Wellness/Preventative Care

Poor Posture

Improved athletic performance

Area(s) of complaint/Concern: \_\_\_\_\_

When did the problem start? \_\_\_\_\_

Was this related to a fall or accident? **Y N** Please describe: \_\_\_\_\_

Describe the pain/problem: \_\_\_\_\_

If any of the following conditions have been experienced in the past, please mark with a “**P**” for past. If any of the following conditions are currently being experienced, please mark a “**C**”. Leave blank any that do not apply.

\_\_\_ Headaches

\_\_\_ Diarrhea

\_\_\_ Neck pain

\_\_\_ Nausea

\_\_\_ Ear infections

\_\_\_ Constipation

\_\_\_ Mid back pain

\_\_\_ Loss of appetite

\_\_\_ Allergies (seasonal)

\_\_\_ Bed-wetting

\_\_\_ Low back pain

\_\_\_ Frequent urination

\_\_\_ Allergies (food/other)

\_\_\_ Colic

\_\_\_ Knee pain

\_\_\_ Frequent thirst

\_\_\_ Sinusitis

\_\_\_ Asthma

\_\_\_ Ankle sprains

\_\_\_ Pain in leg

\_\_\_ Hyperactivity

\_\_\_ Indigestion

\_\_\_ Fatigue

\_\_\_ Mood disorder

\_\_\_ Difficulty sleeping

\_\_\_ Learning Difficulties/delays

\_\_\_ Eczema

\_\_\_ Skin Issues

### Sleep:

**Good**

**Bad**

**Poor**

Current Medications (including over the counter): \_\_\_\_\_

# HEALTH HISTORY

## Birth:

Was the birth assisted?            **Y**        **N**  
If yes, how?    **Forceps**            **Vacuum Extraction**            **C-Section**            **Induced Labor**  
Duration of Birth: \_\_\_\_\_ Was the delivery normal?    **Yes**        **No**  
Any complications at birth? \_\_\_\_\_  
Did your child receive vaccinations?    **Yes**    **No**    If yes, which ones? \_\_\_\_\_  
Did your child react to them?    **Yes**    **No**

## Development:

Does or did your child have any of the following (Please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours, scoot, army crawl) |   |
| <input type="checkbox"/> Difficulty learning to ride a bike                         | <input type="checkbox"/> Appears clumsy                         |
| <input type="checkbox"/> Difficulty learning to read                                | <input type="checkbox"/> Difficulty writing                     |
| <input type="checkbox"/> Difficulty using utensils                                  | <input type="checkbox"/> Difficulty buttoning clothing          |
| <input type="checkbox"/> Difficulty tying shoes                                     | <input type="checkbox"/> Difficult or awkward to walk/run       |
| <input type="checkbox"/> Poor hand-eye coordination                                 | <input type="checkbox"/> Difficulty sitting or paying attention |
| <input type="checkbox"/> Skipped milestone: Roll, Sit, Crawl, Stand, or Walk        |   |

**At what age did your child start to walk unassisted:** \_\_\_\_\_

## Neurological/Other:

Has your child ever been diagnosed by a medical professional with any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment    | <input type="checkbox"/> Visual Impairment               |
| <input type="checkbox"/> Neurological disorders        | <input type="checkbox"/> Anxiety/Depression              |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD                      | <input type="checkbox"/> Tourette's Syndrome             |
| <input type="checkbox"/> Dyslexia                      | <input type="checkbox"/> Other: _____                    |

**If yes, by whom?** \_\_\_\_\_

## General Activities (Check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> heavy backpack (more than 15% of body weight) | <input type="checkbox"/> sleeps on stomach                 |
| <input type="checkbox"/> plays video games _____ hours/day             | <input type="checkbox"/> exercise _____ hours/day          |
| <input type="checkbox"/> soft drinks _____ drinks/day                  | <input type="checkbox"/> computer/ipad use _____ hours/day |

List any sports/recreational activities: \_\_\_\_\_

Do you have any pets at home?            **Y**        **N**

## Food:

Approximate consumption per day: Water \_\_\_\_\_ Milk \_\_\_\_\_ Soda/Other \_\_\_\_\_

Favorite foods list: \_\_\_\_\_

Is your child a picky eater?            **Y**        **N**

If yes, describe: \_\_\_\_\_

C O N S E N T T O E X A M I N E , X - R A Y ,  
A N D T R E A T A M I N O R

I, the parent or legal representative of \_\_\_\_\_ authorize the performance of a diagnostic examination and x-rays of this child or which Leahy Chiropractic P.A. may consider necessary or advisable in the course of treatment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

H I P A A ( H E A L T H I N S U R A N C E P O R T A B I L I T Y  
A C C O U N T A B I L I T Y A C T )

Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Leahy and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

*We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.*

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (#164.524).

This notice is effective as of \_\_\_\_\_, 20\_\_\_\_. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_