ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

Pediatric Intake Form (0-5 years of age)

Patient Information:

Date: _____

Child's Name: _____ DOB: _____

Parent/Guardian's Name: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____

E-mail address: _____

Pediatrician/Phone #: _____/_____

Prenatal History:

Mother's health status prior and during pregnancy: _____

_____

Maternal age for respective pregnancy: _____

How many pregnancies? _____ How many live births?_____

Approximate weight gain during pregnancy:

☐ <15lbs ☐ 15-25lbs ☐ 25-35lbs ☐ 35-45lbs ☐ >45lbs

Complications during pregnancy? Preeclampsia? Eclampsia? _____

_____

Drug use during pregnancy (Rx, OTC, recreational, remedies): _____

_____

Presence of in utero constraint? (Breech position, etc)_____

_____

ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

Natal History:

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Was your Birth Plan Followed? If not, give a brief description of what happened:

_____

_____

Provider: ☐ OBGYN ☐ Midwife ☐ Other: _____

Type of Delivery: ☐ Vaginal ☐ Cesarean

Spontaneous or induced labor (Pitocin):_____

Epidural administered: ☐ Yes ☐ No

Length of labor: ☐ <4 hrs ☐ 8 hrs ☐ 12 hrs ☐ 18 hrs ☐ >24hrs

Instrumentation used: ☐ Vacuum Extraction ☐ Forceps ☐ None

Was an External Cephalic Version (ECV) performed? ☐ Yes ☐ No

Mother's birth position: ☐ On back ☐ Squatting ☐ Other:_____

APGAR score: ☐ At birth _____/10 ☐ At 5 minutes _____/10 ☐ Unsure

Gestational age: ☐ Full term 37-42 weeks ☐ Premature <36 weeks ☐ Post term >42 weeks

Is there anything else you would like me to know about your pregnancy and labor/delivery?

_____

_____

_____

ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

History:

Did you breastfeed your child? ☐ Yes How long? _____ ☐ No

Has your child had any surgeries? ☐ Yes ☐ No

If yes, please list what kind of surgery and how old they were:

_____

Has your child been on antibiotics? ☐ Yes ☐ No

If yes, how often and what for? _____

_____

Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list them: _____

_____

Is your child currently taking any vitamins? ☐ Yes ☐ No

If yes, please list them: _____

_____

Is your child currently teething: ☐ Yes ☐ No

Has your child been vaccinated: ☐ Yes ☐ No ☐ Considering it

If yes, are they on recommended schedule or a delayed schedule? _____

Is your child currently experiencing any of the following:

- ☐ Colic
- ☐ Recurrent ear infections
- ☐ Incoordination while walking
- ☐ Bedwetting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sleep disturbances
- ☐ Difficulty crawling
- ☐ Learning difficulties/Hyperactivity
- ☐ Asthma
- ☐ Allergies
- ☐ Other: _____

ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

SUMMARY

What brings your child to the office today?

_____

When did it start?

_____

Does anything make it better? Yes No If yes, please describe: _____

_____

If no, please list what you have tried: _____

Does anything make it worse?

_____

How long does it last? ☐ All day ☐ Few hours ☐ Minutes

How frequent is the condition: Constant ☐ Intermittent ☐ Night Only ☐ During certain activity

Describe the pain:

☐ Sharp ☐ Dull/Achy ☐ Stabbing ☐ Shooting ☐ Tingling ☐ Other:_____

Does it travel anywhere?

_____

Is it constant or intermittent? (Circle one)

Are there any other symptoms that your child is currently experiencing that may or may not be related to the above condition? _____

_____

Doctors Signature: _____ Date: _____

ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

CONSENT TO TREATMENT OF MINOR

Patient's Name: _____

Parent/Guardian: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Rose and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____