ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

Dr. Korey Rose Dr. Kelsey Rose

395 Landa St. New Braunfels, Texas 78130
Phone: (830) 629-3101 Fax: (830) 626-8245

Pediatric Intake Form (6+ 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? ____

____

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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 experiencing any of the following:

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

Does your child participate in any of the following:

- ☐ Football
- ☐ Soccer
- ☐ Baseball
- ☐ Softball
- ☐ Karate
- ☐ Dance
- ☐ Hockey
- ☐ Gymnastics
- ☐ Volleyball
- ☐ Tennis
- ☐ Swimming
- ☐ Wrestling
- ☐ Rugby
- ☐ Lacrosse
- ☐ Basketball
- ☐ Other: ________________

How many hours per week does your child spend participating in one of the above activities?

☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ 12+ hrs

What other hobbies does your child have? ____

____

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History of Present Illness:

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?

____

What does it feel like?

- Sharp
- Dull/Achy
- Stabbing
- Shooting
- Tingling
- Other:____________________

Does it travel anywhere?

____

Is it constant or intermittent? (Circle one)

Is it currently preventing you from doing anything? ☐ Yes ☐ No

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: _______________

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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 ____________________