2201 52nd Avenue
Moline, IL 61265
(309)-797-0707

Pediatric Patient Intake Form

Patient Information

Last Name_____ MI_____ First Name_____ Date_____

Address_____ City/State/Zip_____

Date of Birth_____ SSN_____ Sex **M / F**

Weight_____ Height_____ Number of Siblings_____

Mother's Name_____ Mother's Employer_____

Home Phone_____ Cell Phone_____ Work Phone_____

Father's Name_____ Father's Employer_____

How were you referred to our office?_____

Reason for visit_____

Has your child ever received chiropractic care? **Yes / No** If yes, for what condition_____

Health History

Name of Pediatrician_____ Date of last visit_____

Reason for visit_____

Current medications and conditions being treated_____

Does your child have any allergies **Yes / No** If yes, please list_____

Has your child ever taken antibiotics? **Yes / No** If yes, for what condition_____

Has your child ever been in an auto accident? **Yes / No** If yes, date and injuries_____

Has your child been injured in any sports? **Yes / No** If yes, describe_____

Has your child ever fallen head first? **Yes / No** If yes, describe_____

Has your child had any broken bones or sprains? **Yes / No** If yes, describe_____

Has your child ever had surgery? **Yes / No** Date and reason_____

Any traumas not listed? **Yes / No** If yes, type and date_____

Childhood Diseases

Has your child had any of the following illnesses? If so, check and provide the age of when they did.
_____Chicken Pox _____Meningitis _____Tuberculosis
_____Whooping Cough _____Mumps _____Rubella _____Other

Current or Past Conditions (Check all that apply)

__Dizziness	__Allergies	__Diarrhea	__Hernias
__ADHD	__Runny Nose	__Poor Appetite	__Neck Pain
__Backaches	__Itchy Eyes	__Bronchitis	__Arm/Elbow Pain
__Heart Condition	__Rashes	__Hyperactivity	__Leg/Hip Pain
__Irregular Heart Beat	__Unusual Moles	__Behavior Issues	__Knee/Foot Pain
__Earaches	__Neuritis	__Poor Memory	__Growing Pains
__Diabetes	__Digestive Trouble	__Insomnia	__Joint Pain
__Tuberculosis	__Sinus Trouble	__Nightmares	__Scoliosis/ Spinal Curvature
__Hypertension	__Cough/Wheeze	__Bed Wetting	__Blood Disorders
__Fevers/Chills	__Chest Pain	__Pain Urinating	__Stomach Aches
__Frequent Colds	__Constipation	__Convulsions	__Paralysis
__Arthritis	__Anemia	__Muscle Pain	__Rheumatic Fever
__Headaches	__Cancer	__Fainting	__Other
__Asthma			

Prenatal History

Location of Birth: __Hospital __Home __Birthing Center __Adopted __Stepchild
Complications during birth **Yes / No** If yes describe_____
Was the birth __Normal __Breech __Cesarean __Vacuum Extraction __Forceps
Birth Weight_____ Birth Height_____
Was there Presence of the following at birth? __Meconium __Cyanosis(Blue) __Jaundice(Yellow)
Congenital (Birth) Defects/Anomalies?_____
Pregnancy Problems? **Yes / No** If yes, describe_____
Did you use any medications during pregnancy? **Yes / No** If yes, list_____
Did you use any alcohol or tobacco during pregnancy **Yes/ No**_____

Feeding History

Breast Fed **Yes / No** How long?_____ Formula Fed **Yes / No** How long?_____
Introduced to solids at _____months. Introduced cow/soy milk at _____months.
Does your child have any food/juice allergies **Yes / No** If yes, list_____

Developmental History

How many hours of sleep at night?____ Naps (number and length)_____
At what age did your child: Crawl_____ Sit alone_____ Stand alone_____ Walk_____ Say words_____

Family History

Family Members-Present and Past Conditions (Example heart disease, cancer, diabetes, etc.)_____
_____

I ATTEST THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

I understand and agree that the health accident/insurance policies are an arrangement between the insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be due immediately and payable.

Signature of Legal Guardian:

_____ Date:_____

Printed Name Legal Guardian _____