PEDIATRIC INTAKE FORM

Winchester Hospital Chiropractic Center
300 Trade Center, Suite 4460
Woburn, MA 01801
781.933.5051
www.winchesterhospitalchiro.com

Child's Name_____ Parent(s) Name_____

Child's Date of Birth_____ Age_____ M / F Height_____ Weight_____

Address_____ Home Phone (_____) _____

Parent's cell (_____) _____Child's pediatrician and location_____

Who told you about our office_____ Reason for today's visit_____

BIRTH MOTHER'S PREGNANCY

Did the mother have any injuries during the pregnancy (accidents, falls, etc.)_____

Any treatment required during the pregnancy (chiro., PT, massage, etc.) _____

Any health problems during the pregnancy (diabetes, pre-eclampsia, bed rest, etc.)_____

Any medications or drugs taken during the pregnancy_____ Did the mother smoke_____

LABOR AND DELIVERY

Problems during labor and delivery_____

Type of birth: Vaginal_____ C-Section_____ Forceps_____ Vacuum Extraction_____ Home Birth_____

Name of Hospital/Delivery Center_____ Was a Midwife or Doula used_____

Length of labor_____ Was labor induced_____ Did the mother have an epidural_____

Baby's birth weight_____ Birth length_____ APGAR Scores_____ Length of Hospital stay_____

Problems with the baby after delivery_____

CHILD'S HEALTH HISTORY

Health problems with the child now or in the past_____

Accidents or injuries to the child (falls, car, sports, broken bones)_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? No Yes

Was the child breast fed____ If so, for how long_____ Was the child bottle fed____ For how long_____

Current milk: Breast____ Formula/Type_____ Cow's milk-what %_____ Soy milk___ Rice milk___

Frequency of eating_____ Current food/snacks_____

Any known food or environmental allergies/intolerances_____

Current medications_____ Current behavior_____

Number of hours of sleep per night_____ Quality of sleep: Good_____ Fair_____ Poor_____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

GENERAL SYMPTOMS Check symptoms the child currently has or has had in the past year

GENERAL
__ADD/ADHD
__Allergies
__Autism/Asperger's
__ Anemia
__Bed Wetting
__Behavioral Problems
__Bladder Infection
__ Broken Bones
__Cancer/Tumors
__Depression
__Diabetes
__Difficulty Sleeping
__Dizziness
__Dyslexia
__Epilepsy
__Fainting
__Growing Pains
__Heart Problems
__Hodgkin's Lymphoma
__Hyperactivity
__Juvenile Arthritis
__Nightmares
__Night Sweats
__Paralysis
__PDD
__Seizures
__Sensory Processing Challenges
__Speech Problems
__Stroke

EYE, EAR, NOSE & THROAT
__Pink Eye
__Vision Problems
__ Dizziness
__ "Crossed" Eyes
__Ringing in Ears
__Hearing Loss
__Earache
__Ear Infections
__Nose Bleeds
__Sinus Problems
__Bad Breath
__Colds-Flu
__Frequent Runny Nose

RESPIRATORY
__Asthma
__Bronchitis
__Pneumonia
__Mononucleosis
__Shortness of Breath
__Cough/Wheeze
__Repeated infections/colds

GASTRO-INTESTINAL
__Poor Appetite
__Excessive Appetite
__Bloating/Gas
__Indigestion
__Nausea
__Reflux
__Constipation
__Diarrhea
__Colitis/IBS
__Hernia

HEAD, NECK and SPINE
__Headaches
__Neck Pain
__Neck Stiffness
__Torticollis
__Midback Pain
__Low back Pain
__Back Spasms
__Scoliosis
__Muscle/joint pain

ARMS and HANDS
__Shoulder Pain
__Broken Collar Bone
__Erb's Palsy
__Elbow Pain
__Dislocated Elbow
__ "Little League Elbow"
__Wrist or Hand Pain
__Numbness or Tingling in arms

HIPS, LEGS and FEET
__Buttocks Pain
__Hip Pain
__Congenital Hip Dysplasia
__Knee Pain
__Ankle or Foot Pain
__Feet/Toes turn in or out
__Bow Legs or KnockKnee
__Walks on Toes
__Flat Feet
__Limp

SKIN
__Cradle Cap
__Baby Acne
__Eczema
__Psoriasis
__Hives
__Rash
__Bumps on back of arms or legs
__Dark circles under eyes or puffiness

CHILDHOOD ILLNESSES
__Chicken Pox
__Colic
__Croup
__Diptheria
__Measles
__Mumps
__RSV
__Rubella
__Tetanus
__Whooping Cough

OTHER:
_____
_____
_____
_____
_____
_____

Authorization for care of a minor: I hereby authorize Winchester Hospital Chiropractic Center and its doctors to administer care as they deem necessary to my son/daughter/ward. I accept responsibility for payment for services rendered. The patient information given is true and complete to my knowledge. I authorize the doctor to take progress photos of my child to be kept in their medical chart.

Signature_____ Relationship_____ Date_____

Witnessed_____ Date_____