Child Initial Intake Form

Date_____AHC#_____

Child's Name _____Birth Date: M____ D____ Y_____Age: _____
Sex: ❍M ❍F Previous Chiropractic Care? ❍Yes ❍No Approximate Last Visit: _____
Parents'/Guardians' Names: _____
Home Phone: _____ Parent's Cell: _____
Home Address:_____
City: _____ PC: _____ _____
Parent's Email address: _____

Reasons for Seeking Chiropractic Care

Please check reasons for pursuing chiropractic care for your child:
____ He/She is continuing ongoing care from another chiropractor.
____ I recently had *my* spine checked and see the value in getting my child checked.
____ I'm concerned about his/her health and I'm looking for answers.
____ He/She has a specific condition that concerns me.
____ I want to improve my child's immune function.

Many of the common health challenges that occur later in life have their origins during the developmental years, some starting at birth. Certain stresses in life start to produce layers of damage to the spine and nervous system. Please answer the following questions, about your child, to the best of your ability.

Child's Current Body Signals

Please check any of the following body signals which he/she has or has *had* previously:

❍ Headaches/Migraines	❍ Frequent Crying Spells	❍ Did not gain weight
❍ Asthma	❍ PDD/Autism	❍ Tonsilitis
❍ Sleep Problems	❍ Seizures	❍ Car Accident
❍ Weight Problems	❍ Frequent Colds	❍ Colic
❍ ADD/ADHD	❍ Allergies	❍ Digestive Problems
❍ Poor Posture	❍ Sinus Problems	❍ Scoliosis
❍ Constipation	❍ Bedwetting	❍ Back Problems
❍ Frequent Diarrhea	❍ Ear Infection	❍ Other: _____

Which of the problems that you have checked off is the worst: _____
Number of doses of antibiotics your child has taken:
During the past 6 months: _____
Total during his/her lifetime: _____
List reasons: _____
Number of doses of other prescription medications your child has taken:
During the past 6 months: _____
Total during his/her lifetime: _____
List reasons: _____

Prenatal History

Adopted ❍Yes ❍No
Complications during *pregnancy*? ❍Yes ❍No Explain: _____
Any exposure to ultrasound during pregnancy? ❍Yes ❍No Number: _____
Medications/drugs/caffeine use during pregnancy? ❍Yes ❍No List: _____
Cigarette/Alcohol use during pregnancy? ❍Yes ❍No
Location of birth: ❍ Hospital ❍Birthing Center ❍ Home ❍ Other: _____

Birth History

Complications during delivery? ❍Yes ❍No If yes: ❍Forceps ❍Cesarean ❍Breech ❍Vacuum
❍ Mother Induced ❍ Mother medicated (Epidural, Pitocin, etc.) ❍ Baby given medication
❍ Other: _____
Genetic Disorders or Disabilities? ❍Yes ❍No List:_____
Breast Fed? ❍Yes ❍No How Long? _____ Formula Fed? ❍Yes ❍No How Long? _____
Food or Other Allergies? ❍Yes ❍No List: _____
What was the baby's APGAR Score at 1 minute? _____ /10 & at 5 minutes? _____ /10 ❍Unsure
Was there initial respiratory delay? ❍Yes ❍No Purple markings on face? ❍Yes ❍No
Mis-shaped skull/head? ❍Yes ❍No

Vaccination History

If you vaccinated, what vaccinations and age given? _____
Any negative reactions? ❍Yes ❍No List: _____
Reason for vaccination? ❍Informed decision ❍Didn't know I had a choice ❍Recommended
According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child? ❍Yes ❍No List: _____
Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, martial arts, etc.)? ❍Yes ❍No List: _____
Has your child been seen in an emergency room? ❍Yes ❍No List: _____
Any Surgeries? ❍Yes ❍No List: _____

Consent to evaluation of a minor child

I _____ being the parent or legal guardian of _____
(*print name of consenting adult*) (*print name of minor*)
hereby grant permission for my child to receive a chiropractic evaluation by Dr. Cameron and his associates and they have my permission to perform an X-ray evaluation, if necessary.

_____ _____
Consenting Adult's Signature Date