Walton Clinic of Chiropractic
Pediatric Intake Form

Patient Information:

Date: _____

Child's Name: _____ DOB: _____

Parent / Guardian's Name: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____

E-mail Address: _____

Referred By: _____

Has your child been checked by a Doctor of Chiropractic? Yes No

If yes, please provide the name of the office / doctor. _____

Were x-rays taken? Yes No

Who is your medical pediatrician? _____

Prenatal History:

Is your child adopted? Yes No

Did you have any complications and when? _____

Did you smoke? Yes No

Did you consume alcohol? Yes No

Did you take medication? Yes No

If yes, what was the reason for the medication? _____

Birth History:

Did you have ultrasound during this pregnancy? Yes No

What was the frequency? _____

Place of Birth: Home Birthing Center Hospital

Provider: Midwife OB-Gyn Other

Type of Birth: Vaginal C-section Other:_____

Were main medications used? Yes No

Was labor induced? Yes No

If yes, why? _____

What position did you deliver in? Squatting On back Other

Birth Trauma? Doctor Assisted Twisting and/or Pulling Vacuum Extraction Forceps

Newborn Trauma (medical procedures and tests):

APGAR score: birth_____/10 5-minutes_____ Unsure

Were there purple marks on their face? Yes No

Did you breastfeed your child? Yes No

Does your child prefer one breast over the other? Yes No

If yes, which side? Right Left

Does your child have any food allergies? Yes No

If yes, please list: _____

Has your child been immunized? Yes No

Reason for vaccination? Informed decision Recommended Didn't know I had a choice

Did your child have any negative reaction to the vaccinations? Yes No

Were they reported? Yes No

Has your child ever had any surgeries? Yes No

If yes, please elaborate: _____

Has your child been on antibiotics? Yes No

If yes, how often and what for? _____

Is your child currently taking any medication? Yes No

Is your child currently taking and vitamins? Yes No

Baby / Toddler (0-4):

Have any of the following occurred?

Fall from a changing table	Frequent crying spells	Tumble down stairs
Fall off playground equipment	Fall out of crib	Involvement in MVA
Play in Johnny Jumper	Frequent ear infections	Tonsillitis
Reaction to vaccines	Frequent fevers	Frequent diarrhea
Repeated infections or colds	Sleeping problems	Constipation
Colic	(+ or -) weight gain	

Other (please explain): _____

Child (5-12) :

Have any of the following occurred?

Fall from a tree	Fall off of a bicycle	Sports accident	Car accident
Stomach pains	Scoliosis	Bed wetting	Fall on playground
Asthma	Learning difficulties	Allergies	Hyperactivity / Autism
Leg / Knee pains	Other (please explain): _____		

_____

Which of the above bothers your child the most? _____

When did it begin? _____

Is it getting worse? Yes No

Is the pain: Constant Intermit Cyclic

Effect on activity? Not at all Somewhat Always

Does your child participate in any of the following?

Soccer	Football	Gymnastics	Karate
Hockey	Lacrosse	Basketball	Dance
Wrestling	Baseball / Softball	Volleyball	Tennis
Swimming	Rugby	Other: _____	

How would you rate your child's diet? Well balanced Average High sugar / processed food

Does your child consume artificial sweeteners? Yes No

Fluoridated water? Yes No

Number of hours your child sleeps? _____ hours per day

Sleep quality? Good Fair Poor

Financial Information :

Who is responsible for the account? _____

Method of payment? (circle one) Cash Check Credit Card Other

Insurance Co _____ Policy #_____

Insured's DOB _____

Name of Insurance Company: _____

Policy #: _____

Insured's Name _____

Insured's Date of Birth _____

Insured's Social Security #: _____

Secondary Insurance Co. _____

Policy # _____

AUTHORIZATION FOR CARE TO A MINOR

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collection this account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I hereby agree this office and its Doctors to administer care to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by this office.

Signed: _____ Witnessed: _____

Date: _____