**CHILD INTAKE FORM**

ABOUT THE PATIENT DATE_____/_____/_____

Child's Name: _____ SS # _____-_____-_____

LAST FIRST MI

Date of Birth: ____ / ____ / ____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name:_____

Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Parent's email: _____

Emergency Contact: _____ Relation: _____

Whom may we thank for referring you? _____

How did you hear about us? ☐Google ☐Facebook ☐Family/Friend ☐Other:_____

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child

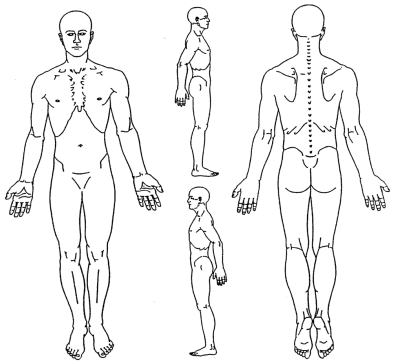
Parent/Guardian Signature:_____

REASON FOR VISIT

Current Health Concern: _____ When did this condition start: _____ / _____ / _____

How did the problem start: ☐Suddenly ☐Gradually ☐Post-Injury ☐Other: _____

**Please CIRLCE your area(s) of main complaint**



**How do your symptoms currently feel?**

0 1 2 3 4 5 6 7 8 9 10

(**No Pain**) (**Unbearable**)

**Percentage of the day spent in pain?**

25% 50% 75% 100%

How has your child's symptoms progressed: ☐Same ☐Better ☐Worse

Describe your child's symptoms: _____

☐Sharp ☐Dull ☐Aching ☐Burning ☐Numbness ☐Tingling ☐Throbbing

☐Stabbing ☐ OTHER _____

Does anything relieve the problem? If yes, please list - ☐No ☐Yes_____

Does anything make the problem worse? If yes, please list ☐No ☐Yes_____

Has your child experienced this problem before? ☐No ☐Yes

Please Explain: _____

Has your child had treatment for this condition before? ☐No ☐Yes

Please Explain: _____

Does the condition interfere with any of the following:

☐Sleep ☐Sitting ☐Lifting ☐Bending ☐Standing ☐Crawling

☐Lying Down ☐Walking ☐Feeding ☐OTHER _____

**GOALS**

We want to make sure you get the absolute best chiropractic care and the best service therefore we want to know **your TOP functional goals** that you have with your child's care with us:

☐Better Sleep ☐More Sleep for Mom/Dad ☐Eats better

☐More Pooping ☐Better Latch/Breastfeeding ☐Better focus

☐Less Stress for Mom/Dad ☐Less sick days ☐ Better attitude

☐Less Anxious Tendencies ☐Less Ear infections ☐Off or less medication

☐OTHER _____

PREVIOUS TREATMENT

Pediatrician: _____ Date of last visit: _____ / _____ / _____

Previous Chiropractic Care: ☐No ☐Yes Name: _____ Date of last visit: _____ / _____ / _____

OTHER: _____

Previous Diagnosis: _____

PAST MEDICAL HISTORY

Please mark any of the following that your child has currently or has had previously.

☐ Thumb sucking
☐ Diarrhea or constipation
☐ Irritable/temper problems
☐ Nightmares/sleep problems
☐ Ever eaten dirt, paint, or plaster
☐ Child doesn't get along well with other children
☐ Problems with school/schoolwork
☐ Did mother smoke cigarettes, use alcohol or drugs, or any medications used during pregnancy:_____
☐ Toilet training problems
☐ Hearing problems
☐ Emotional disorders
☐ Dental problems
☐ Bed-wetting
☐ Eye problems
☐ Speech problems
☐ Discipline problems
☐ Epilepsy
☐ Developmental problems
☐ Mumps, Measles
☐ Chicken Pox
☐ Eczema/Skin problems
☐ Asthma/Wheezing
☐ Croup
☐ Pneumonia
☐ HIV/AIDS
☐ Abnormal bleeding
☐ Hemophilia
☐ Hepatitis
☐ Cancer
☐ Night Sweats
☐ TB/ Lung Disease
☐ High blood pressure
☐ Kidney/Bladder problems
☐ Sexually transmitted infection
☐ High cholesterol
☐ Handicaps/Disabilities
☐ Diabetes
☐ Rheumatic fever
☐ Congenital heart defect
☐ Heart murmur
☐ Broken bones:_____
☐ Major trauma, falls, or car accidents:_____

Was/Is the child breast-fed? ☐No ☐Yes
Age discontinued breastfeeding:_____

Has your child been vaccinated? ☐No ☐Yes
If so, which ones and list reactions to them:_____

Is your child currently on any medications?
☐No ☐Yes If so, please list:_____

Is your child currently on any supplements?
☐No ☐Yes If so, please list:_____

Has your child ever been on any antibiotics?
☐No ☐Yes How many courses:_____

**Delivery**
☐C-section
☐Vaginal

Were forceps or vacuum extraction used during delivery? ☐No ☐Yes
What gestation week was the child born:_____
Were any of the following used throughout pregnancy: ☐Midwife ☐Doula ☐Chiropractor

Any evidence of birth trauma (bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other):_____

At RAK Chiropractic we want to offer THE best possible care to our patients.

We have had great success in helping our patients with many other conditions.

Please mark any/all that apply to you so that RAK can help you achieve to be your best.

**Do you currently / Have you ever experienced any of the following:**

| | | | | |
|---|---|---|---|---|
| ☐Bed-Wetting | ☐Constantly Sick | ☐ADD | ☐Head tilt | ☐Stomach Pain (Gas/Bloat) |
| ☐Ear Infections | ☐Depression / Anxiety | ☐Infertility | ☐Chronic Sinus Infections | ☐Allergies |
| ☐Constipation | ☐Asthma | ☐Eczema/Rashes | ☐Colic | ☐Spit Up |

☐Other: _____

_____
Patient Name

_____
Parent/ Guardian Signature

_____ / _____ / _____
Date