healthyliving
CHIROPRACTIC CLINIC

Dr. Marie-Andrée Gélinas, D.C.
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Pediatric Intake Form (Birth to 12 years)

The Child's Name____

Address___________________________________City_______________State_______ Zip____________

Gender: ❑ M ❑ F Birth date_____/_____/_____ Age______ Social Sec. #: ____________________

Parent(s) Names ____

Emergency Contact ___________________________ Relation ______________ Phone # ____________

Has he/she ever had chiropractic care before? ❑ Yes ❑ No Reason? ____________________________

Present Health Challenge(s):

What is the reason for your visit today?____

What do you feel is the cause of your child's problem?______________________________________

When did you first notice this sign of body dysfunction?____________________________________

Is this dysfunction getting progressively worse? ❑ Yes ❑ No

If yes, why do you think so?____

What are the most significant measures you have taken to date to improve your child's present health challenge?____

____

Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

____

____

Please list any and all other concerns regarding his/her health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

____

____

Review of Systems:

Below is a list of symptoms that may seem unrelated to the purpose of your visit today, however, these questions must be answered carefully as the problem can affect the overall health of the child.

Please check any symptoms the child experiences:

❑ Allergies ❑ Frequent colds ❑ Congestion ❑ Upper respiratory Infections ❑ Asthma ❑ Ear infections

❑ Sore throat ❑ Colic ❑ Diarrhea ❑ Constipation ❑ Stomach Aches ❑ U-tract infections ❑ Poor appetite

❑ Thrush mouth ❑ Chronic diaper rash ❑ Eczema/psoriasis/skin rashes ❑ ADD/ADHD ❑ Irregular sleep

❑ Bed wetting ❑ Headache ❑ Anxiety ❑ Mood swings ❑ Bruising ❑ Hearth trouble ❑ Fainting

❑ Seizures ❑ Diabetes ❑ Other____

Known allergies: ____

Current Medications: *List ANY/ALL medications he/she is **currently** taking and list the reason why. Be Specific.*

Medication	*Dosage*	*Reason*	*How long have he/she been taking this?*

Immunization History:

Has your child been immunized? ❑ Yes ❑ No

If yes, reason for vaccination? ❑ informed decision ❑ recommended ❑ didn't know I had a choice.

Did he/she have any reaction to the vaccination? ❑ Yes ❑ No Explain: ______________________________

Hospitalization(s) & Surgery(ies):

Has he/she ever been hospitalized? ❑ Yes ❑ No
If yes, why and when? (Please list in chronological order)

____

____

Traumas:

Please list any and all injuries experienced how they occurred and what action was taken to correct them. (Fall, Car accident, abuse, etc)

____

____

Social Life:

How many hours does he/she sleeps daily? ______ What is the quality of Sleep?: ❑ Good ❑ Fair ❑ Poor

Was he/she adopted? ❑ Yes ❑ No *If yes,* how old was he/she at the time? ___________

Does he/she has any brother or sister? ❑ Yes ❑ No
If yes, list the siblings Name, Age and Sex: ____

____

Please check any of the following sports activities that your child is engaged in:

❑ Football ❑ Bowling ❑ Baseball/Softball ❑ Gymnastics/Trampoline ❑ Tennis ❑ Skateboarding ❑ BMX/Motocross ❑ Soccer ❑ Hockey ❑ Snowboarding ❑ Swimming ❑ Track/Field ❑ Volleyball ❑ Skiing ❑ Golfing ❑ Other: __________________________________

Has your child ever been injured while playing sports? ❑ Yes ❑ No
If yes, what type of injury(s) occurred?____

____

____

Birth History:

Birth Weight ________ Birth Length ________ APGAR Scores: _____/10__ (1 min) _____/10__ (5 mins)

Type of Birth: ❑ Vaginal ❑ Forceps/Vacuum ❑ Breech ❑ Cesarean ❑ Home ❑ Birthing Center ❑ Hospital

Any problems during pregnancy and/or labor? ____

____

____

Jaundice (yellow) at Birth? ❑ Yes ❑ No Cyanosis (blue)? ❑ Yes ❑ No

Congenital Anomalies/Defects: ____

Infant Feeding: ❑ Breast ❑ Bottle ❑ Formula ❑ Other: ____

AUTHORIZATION TO TREAT A MINOR

I, ____________________________the undersigning parent/guarding having legal custody/guardianship of - ______________________________, a minor, understand and agree that the physical exam and x-rays are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept my child as a patient. If x-rays or other studies are necessary before treatment begins I will be notified.

I do hereby authorize, request and direct Dr. Marie-Andrée Gélinas, D.C. and whomever she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient: ______________________________ Signature: ______________________________

Print Name *Parent / Legal guardian*

CONSENT TO X-RAY A MINOR CHILD

I understand that Dr. Marie-Andrée Gélinas, D.C. typically don't take x-rays on a minor child under the age of 12 years old unless she may consider necessary or advisable in the course of examination and treatment.

I authorize the performance of diagnostic x-rays and diagnostic examination of my child.

Patient: ______________________________ Signature: ______________________________

Print Name *Parent / Legal guardian*