

Dr. Danielle Rothman, DC, FIPCA

PEDIATRIC INTAKE FORM

Patient (Child) Name:

Date:

Address:

Sex: Male Female

Date of Birth:

Height:

Weight:

Patient SSN:

Name of Parents/Guardians:

Home Phone:

Cell Phone:

Work Phone:

Email:

Authorized Representative/Parent/Guardian:

PRESENT COMPLAINT

Describe complaint:

When did this begin?

Was there an accident of injury involved? Yes No

Has your child had any past treatments for this complaint? Yes No

Describe:

Current medications:

Symptoms: Please check any current or past problems your child has on the list below.

☐ Dizziness

☐ ADHD

☐ Backaches

☐ Heart Condition

☐ Chronic Earaches

☐ Diabetes

☐ Tuberculosis

☐ Hypertension

☐ Fever/Chills

☐ Frequent Colds

☐ Arthritis

☐ Headaches

☐ Asthma

☐ Pain Urinating

☐ Convulsions

☐ Paralysis

☐ Allergies

☐ Runny Nose

☐ Itchy Eyes

☐ Rashes

☐ Unusual Moles

☐ Neuritis

☐ Digestive

☐ Anemia

☐ Rheumatic Fever

☐ Diarrhea

☐ Poor Appetite

☐ Hyperactivity

☐ Behavioral

☐ Poor Memory

☐ Insomnia

☐ Nightmares

☐ Bed Wetting

☐ Convulsions

☐ Muscle Pain

☐ Fainting

☐ Broken bones

☐ Sprains/Strains

☐ Sinus Trouble

☐ Cough/Wheeze

☐ Hernias

☐ Neck Pain

☐ Arm/Elbow Pain

☐ Leg/Hip Pain

☐ Knee/Foot Pain

☐ Growing pains

☐ Joint Pain

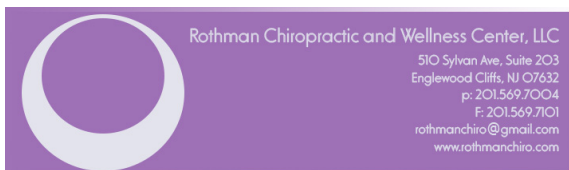
☐ Scoliosis

☐ Blood disorders

☐ Stomach Aches

☐ Other:

Additional Notes:



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PRENATAL + GENERAL HISTORY

Any complications during pregnancy?

Yes No

Explain:

Cigarettes or alcohol during pregnancy? Yes No

Medications taken during pregnancy:

Birth Intervention: Forceps Vacuum C-Section

Complications during delivery? Yes No

Explain:

Genetic disorders or disabilities:

How many times has your child been prescribed antibiotics in the past 6 months?

Total during lifetime?

Has your child received vaccinations? ___ Yes ___ No

Vaccination History:

☐ HBV / Hep B (Hepatitis B) – Age ___

☐ MMR (Measles, Mumps, Rubella) – Age ___

☐ DTP or ☐ DTaP (Diphtheria, Tetanus, Pertussis) – Age ___

☐ Varicella (Chicken Pox) – Age ___

☐ HbCV / Hib (H. influenzae type b conjugate) – Age ___

☐ PCV (Pneumococcal) – Age ___

☐ OPV (Oral Polio Vaccine) or ☐ IPV (Inactivated Poliovirus) – Age ___ Adverse Reactions to Any Vaccine? Y/N List:

FEEDING HISTORY:

Breastfed?	Yes	No	How long:
Formula Fed?	Yes	No	How long:
Intro to solids at:	months		
Cow's milk at:	months		
Food allergies/intolerances:	Yes	No	List:

CHILDHOOD DISEASES:

Chicken Pox: Yes No Age: _____

Rubella: Yes No Age: _____

Rubeola: Yes No Age: _____

Mumps: Yes No Age: _____

Whooping Cough: Yes No Age: _____

Other: _____ Age: _____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed _____ Date: _____