Rothman Chiropractic and Wellness Center, LLC
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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.	__Allergies	__Muscle Pain
__Dizziness	__Runny Nose	__Fainting
__ADHD	__Itchy Eyes	__Broken bones
__Backaches	__Rashes	__Sprains/Strains
__Heart Condition	__Unusual Moles	__Sinus Trouble
__Chronic Earaches	__Neuritis	__Cough/Wheeze
__Diabetes	__Digestive	__Hernias
__Tuberculosis	__Anemia	__Neck Pain
__Hypertension	__Rheumatic Fever	__Arm/Elbow Pain
__Fever/Chills	__Diarrhea	__Leg/Hip Pain
__Frequent Colds	__Poor Appetite	__Knee/Foot Pain
__Arthritis	__Hyperactivity	__Growing pains
__Headaches	__Behavioral	__Joint Pain
__Asthma	__Poor Memory	__Scoliosis
__Pain Urinating	__Insomnia	__Blood disorders
__Convulsions	__Nightmares	__Stomach Aches
__Paralysis	__Bed Wetting	__Other:
	__Convulsions	

Additional Notes:

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PRENATAL + GENERAL HISTORY

Any complications during pregnancy?
Yes No Explain:

Medications taken during pregnancy: Cigarettes or alcohol during pregnancy? Yes No

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:

- O HBV / Hep B (Hepatitis B) – Age __
- O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age __
- O HbCV / Hib (H. influenzae type b conjugate) – Age __
- O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age __
- O MMR (Measles, Mumps, Rubella) – Age __
- O Varicella (Chicken Pox) – Age __
- O PCV (Pneumoccocal) – 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: _____