EVOLVE chiropractic

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PEDIATRIC INTAKE
Infants – School Aged Children

PATIENT INFORMATION

Child's Name:_______________________ Parent/Guardian Name:_______________________

Address: _______________________City_______________ State_________ Zip: __________

Gender: ☐Male ☐Female D.O.B:______/______/______ Age__________

Current Height:__________ Current Weight:__________

Home Phone: _______________ Cell Phone: _______________Cell Provider:__________

☐ Yes! I want text appt reminders!

How did you hear about us? _______________________

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Has your child been adjusted by a chiropractor before? ☐YES ☐NO

If yes, reason for those visits: _______________________When was the last visit?__________

Is your child currently receiving care from other health professionals?

☐YES ☐NO If yes, list name and specialty: _______________________

Who is your families primary care physician?_______________ Contact info:__________

HEALTH HISTORY

Describe the health concern that prompted this visit:_______________________

When did this concern begin? __________How did this concern begin? _______________

Has this condition: ☐Worsened ☐Stayed the same ☐Been Intermittent

Does this interfere with: ☐ School ☐ Sleep ☐ Daily Routine ☐ Family

What makes this condition worse? _______________________

What makes this condition better? _______________________

Has your child seen anyone else for this concern? ☐YES ☐NO Type of treatment:__________

Please list any medications your child is currently taking. Include dosage and frequency (including OTC):__________

____

BIRTH INFORMATION

Child's birth was at: ☐Home ☐Birthing Center ☐Hospital

OB/Midwife/Physician was:____

Child birth was: ☐**Natural vaginal with no medications**

☐**Vaginal with interventions**: ☐Pitocin ☐ Epidural ☐Pain Medications

☐Vacuum Extraction ☐Forceps ☐IV antibiotics

☐Other:__________________________________

☐**C-Section:** ☐Scheduled ☐Emergency

☐Adopted ☐Prenatal history unknown ☐Birth history unknown

Was your child at anytime during your pregnancy in a constrained position?: ☐ YES ☐NO ☐ UNSURE

If yes, please describe: ☐Breech ☐Transverse ☐Face/Brow presentation

Complications during pregnancy: ☐ YES ☐NO (If yes, describe)__________________________________

____

Medications during pregnancy: : ☐YES ☐NO (If yes, describe)__________________________________

If so, which ones and how often? (include OTC):____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐YES ☐NO (If yes, describe)____

Birth Weight:________lbs _________oz Birth Height:__________________

TRAUMAS/INJURY

Please list all hospitalizations and surgical history (include year):____

____

____

Please list any major injuries, accidents, falls and/or fractures you child has sustained in his/her lifetime:

____

____

The human body is designed to be healthy! The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and *impeding your child's ability to heal.*

What signals has your child's body been communicating?

CURRENT PREVIOUS

☐ ☐Asthma
☐ ☐Respiratory Tract Infections
☐ ☐Sinus Problems
☐ ☐Ear Infections
☐ ☐Tonsillitis
☐ ☐Strep Throat
☐ ☐Frequent Colds/Croup
☐ ☐Recurrent Fevers
☐ ☐Eczema
☐ ☐Rashes
☐ ☐Allergies
☐ ☐Food Sensitivities
☐ ☐Digestive Problems

CURRENT PREVIOUS

☐ ☐Frequent Diarrhea
☐ ☐Constipation
☐ ☐Flatulence
☐ ☐Headaches/Migraines
☐ ☐Neck Pain
☐ ☐Torticollis/Head Tilt
☐ ☐Trouble Nursing
☐ ☐Back Pain
☐ ☐Growing Pains
☐ ☐Scoliosis
☐ ☐Red, Swollen, Painful Joints
☐ ☐Colic
☐ ☐Frequent Crying Spells

CURRENT PREVIOUS

☐ ☐Failure to Thrive / Slow Weight Gain
☐ ☐Slow or Absent Refluxes
☐ ☐Asymmetrical Crawling or Gait
☐ ☐Weight Challenges
☐ ☐Bed Wetting
☐ ☐Sleeping Problems
☐ ☐Night Terrors
☐ ☐Tip Toe Walking
☐ ☐Sensory Processing Issues
☐ ☐Seizures
☐ ☐Tremors / Shaking
☐ ☐ADD / ADHD
☐ ☐Autism

Other:____

What is your primary goal for your child at our clinic?

____

____

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation.

Dr. Alec is certified in both pregnancy and pediatrics, is certified in the Webster Technique and is a member of the International Chiropractic Pediatric Association.

WRITTEN CONSENT FOR A CHILD

Name of patient who is a minor/child:____________________________________

I authorize Dr. Alec Nassirzadeh and any/all Evolve Chiropractic staff to perform diagnostic procedures, radiographic evaluation, chiropractic adjustments, and to render chiropractic care to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered in any way, I will immediately notify Evolve Chiropractic.

Date: ____________________ Guardian Signature:____________________

WITNESS:____________________ RELATIONSHIP TO MINOR:____________________