# Apex Health

## Pediatric Patient Intake

**Child Information** Date:_______________

First Name: _________________________ Middle Initial: ________ Last Name:_____________________

Address: ______________________________________________________________________

City: ________________________________________ State:_______________ Zip Code:______________

Home Phone: (_____)______-_______ Ethnicity:_________________

Date of Birth: ____/____/_______ Sex: Male / Female

Family Medical Doctor: ___________________________________ Location:________________________

**Parent or Gaurdian info**

Name: ____________________________________________ Work Phone: (_____)________-___________

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Please describe your occupation(s):__________________________________________________________

**Chiropractic Health History**

Has your child received chiropractic care in the past? Y / N When? ________________________________

Why?________________________________ Chiropractors Name:_________________________________

Primary reason(s) for seeking chiropractic care today:_____________________________________________

______________________________________________________________________________________

Have they seen anyone else for this condition? Y/N Who?____________________________________

How did you hear about us?__________________________________________________________________

**Past Health History**

Check any of the following conditions your child has suffered from during the last 6 months:

| | | | | |
|---|---|---|---|---|
| ☐ Ear Infections | ☐ Scoliosis | ☐ Seizures | ☐ Chronic Colds | ☐ Headaches |
| ☐ Asthma/Allergies | ☐ ADHD | ☐ Recurring Fevers | ☐ Colic | ☐ Growing/Back Pain |
| ☐ Bed Wetting | ☐ Car Accident | ☐ Digestive Problems | ☐ Temper Tantrums | ☐ Whooping Cough |
| ☐ Chicken Pox | ☐ Rubella | ☐ Rubeola | ☐ Mumps | ☐ Other |

Please list any other health conditions your child has experienced in the last 6 months:________________

______________________________________________________________________________________

______________________________________________________________________________________

Please list any current medications or supplements and the reasoning behind them:_________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Number of Doses of Antibiotics your child has taken: ☐ **None**

Past 6 months:______________________ Total during his/her lifetime:______________________________

**Allergic/Immunologic** ☐ **No to all**

☐ Hives ☐ Immune Disorder ☐ HIV/AIDS ☐ Allergy Shots ☐ Other

Explanation:______________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

☐ Food Intolerance ☐ Medication intolerance ☐ Other

Please list all known allergies:________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Has your child received any vaccinations? Y/N If yes please list any and all that you can remember:

______________________________________________________________________________

______________________________________________________________________________

**Developmental History**

The first years of life are when your child is most vulnerable to stress and should be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

__________ Respond to Sound __________ Respond to Visual Stimuli __________ Hold Head Up

__________ Sit Up __________ Cross Crawl ___________ Stand Alone __________ Walk Alone

Did your child reach all set goals on time? ☐ Yes ☐ No

If No what goals were slow or not reached?_______________________________________________________

Any prior surgeries? ☐ Yes ☐ No

If yes please explain:_____________________________________________________________________

**Prenatal History:**

Name of Obstetrician/Midwife:_______________________________________________________________

Complications during pregnancy? ☐ Yes ☐ No

If Yes please explain:_____________________________________________________________________

Ultrasounds during pregnancy? ☐ Yes ☐ No Number:__________________

Medications during pregnancy/ delivery? ☐ Yes ☐ No

If yes please list:_________________________________________________________________________

Cigarette/ Alcohol use during pregnancy? ☐ Yes ☐ No

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home ☐ Other:____________________________

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Ceasarian Section: ☐ Emergency ☐Planned

Complications during delivery? ☐ Yes ☐ No

If yes please explain:_____________________________________________________________________

Genetic Disorders or Disabilities? ☐ Yes ☐ No Explain:_____________________________________

Was delivery within 2 weeks of due date? ☐ Yes ☐ No # of days premature/late:__________________

**Feeding History:**

Breast fed: ☐ Yes ☐ No How long?__________

Formula Fed: ☐ Yes ☐ No How long?___________ Type:_________________________________

Introduced: Solids at: __________ Months, Cows or Goats milk at: __________ Months

Any special diet? ☐ Yes ☐ No

What and for What reason?_________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Current Lifestyle of Parent(s)**

**Physical**

How often do you exercise? ☐ Daily ☐ Often ☐ Occasionally ☐ Rarely ☐ Never Hours per week?:_____

Do you stretch daily? Y/N Do you pay attention to your posture? Y/N

Please list your hobbies or activities: _____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Bio-Chemical**

Do you smoke or have you in the past? Y/N If yes how often and how much?_______________________

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often day/week?______________________

Do you eat prepared, processed or fast foods? Y/N How often?____________________________________

Do you consume carbonated or drinks high in sugar daily? Y/N How often do you drink water?_________

Are you on any special diet? Y/N  If yes for what reason?________________________________________
Your diet emphasizes fruits, vegetables, whole grains, lean meats and other protein sources and is low in sugar and artificial sweeteners?  Y/N   please rate your diet 10 being healthy:  1 2 3 4 5 6 7 8 9 10.

**It is important that our patients and we have the same health objectives concerning chiropractic and wellness care.  Regardless of what a disease or condition is called our practice objective is to eliminate a major interference to the expression of the body's internal ability to heal and thrive. By adjusting the spine, removing subluxations, we help restore the neurological communication of the brain to the body and improve the biomechanical supports of this system.  With the addition of lifestyle, nutrition and exercise recommendations we support the healing of this system and therefore maximize the bodies inborn abilities, bringing you beyond the comfort zone of no symptoms and constantly challenge you to reach for optimal health! Your signature here verifies that the information provided on this form is complete and correct and that you are willing to begin your journey with chiropractic care!**
**Patient Signature: ____________________________________________________ Date:_____________**