Blau Family CHIROPRACTIC & INTEGRATED WELLNESS
Care. Educate. Serve
641 LATTON LANE
PORTAGE, WI 53901
(608) 742 -1300
blauchiropractic.com

Pediatric Intake

Patient Name: _____Today's Date: _____

Parents' or Guardians' Names: _____

Mailing Address: _____City: _____St: ____ Zip: _____

Guardians' Primary Phone (circle one) home/cell/work #: _____Guardians' Secondary Phone (circle one) home/cell/work #: _____ Email Address: _____

☐Male ☐Female Birth Date: _____Current Age: ____

Emergency Contact Name/Number: _____ Relationship: _____

Preferred Language: _____Race: _____Ethnicity: _____

Has the patient seen a chiropractor before? ☐Yes ☐No If yes, when? : _____

Whom may we thank for referring you to our office? : _____

Please check √ all symptoms the patient has ever had, even if they do not seem related to their current problems:

☐ Back pain	☐Headaches	☐Asthma
☐Back Curvature	☐Chest Pain	☐Allergies
☐Mental / Emotional Disorders	☐Difficult Breathing	☐Ringing in Ears
☐Diabetes	☐Heart Problems	☐Cancer
☐Swollen or Painful Joints	☐Numbness or Tingling	☐Convulsions / Epilepsy
☐Skin Problems	☐Carpal Tunnel Syndrome	☐Low Blood Pressure
☐Bruise easily	☐Dizziness	☐High Blood Pressure
☐Hearing Loss	☐Liver Trouble	☐Frequent Colds
☐Loss of Balance	☐Gall Bladder Trouble	☐Digestive Problems
☐Stiffness	☐Excessive Gas	☐Depression
☐Pain with cough, or strain	☐Constipation	☐ADHD
☐Growing Pains	☐Diarrhea	☐Anxiety Disorder
☐Eating Disorder	☐Temper Tantrums	☐Recurring Colds/Fevers
☐Kidney Problems	☐Trouble concentrating	☐Stroke
☐Frequent Urination	☐Loss of memory	☐ Menstrual Problems / PMS
☐Ear Infections	☐Trouble sleeping	☐Learning Disability
☐Colic	☐Bed-wetting	☐ Other, what? : _____

Number of Doses of Antibiotics the patient has taken during the past 6 months: _____ Total during lifetime: _____

Number of Doses of Prescription Medications the patient has taken during the past 6 months: _____ Total during lifetime: _____ Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications during Pregnancy? ☐N ☐Y, List (if any): _____

Ultrasounds during Pregnancy? ☐N ☐Y, How many (if any):_____ Tobacco/Alcohol Use during Pregnancy?☐N ☐Y

Medications during Pregnancy/ Delivery? ☐N ☐Y List (if any): _____

Location of Birth: ☐Hospital ☐Birthing Center ☐Home Birth Intervention: ☐Forceps ☐Vacuum Extraction

---------- ☐Caesarian Section; ☐ Emergency or ☐Planned?

Complications during Delivery? ☐N ☐Y List (if any): _____

Genetic Disorders or Disabilities: ☐N☐Y List (if any): _____

Birth Weight: _____ Birth Length: _____ APGAR Scores:_____

Feeding History:

Breast Fed: ☐N ☐Y How Long: _____ Formula Fed: ☐N ☐Y How long: _____ Type: _____

Introduced to Solids at: ___Months, Cow's Milk at ____Months

Food/Juice Allergies or Intolerances: ☐N ☐Y, List (if any): _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractor for prevention and early detection of vertebral subluxation (spine nerve interference). Was our child able to meet all "milestones" within average recommended timelines?

☐Respond to Sound ☐Cross Crawl ☐Respond to Visual Stimuli ☐Stand Alone
☐Hold Head Up ☐Walk Alone ☐Sit Up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? ☐N ☐Y

Is / Has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading. Marital Arts, etc.)?☐ N ☐Y List (if any): _____

Has Your Child Ever Been involved in a Car Accident? ☐ N ☐Y List (if any): _____

Has Your Child Ever Been Seen on an Emergency Basis? ☐N ☐Y List (why):_____

Any Surgeries: ☐N_____ ☐Y List type and year (if any): _____

Childhood Diseases (please check if the patient has had any of these disease and provide the age in the space provided)**:**

☐Chicken Pox _____ ☐Rubella_____ ☐Whooping Cough_____ ☐Mumps

FOR FEMALE PATIENTS ONLY: has the patient had a menstruation: ☐N ☐Y Age of 1st menses: ___

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial here to indicate you have been made aware of its availability: _____

The statements made on this form and accurate and true to the best of my recollection and I agree to allow this office to examine the minor patient for further evaluation. By signing this form you are waiving receipt of a clinical summary after every visit. You have the right to request a copy of your notes at any time.

I hereby authorize this office and its Doctors to administer care to this child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent (or guardian) Signature: _____ Date: _____