KEYSTONE CHIROPRACTIC
320 Bawden St. Unit 306 Anchorage, AK 99901
Phone (907) 225-6815; Fax (907) 225-5767

Pediatric Intake Form (Birth to 12 years)

Patient Information:

Date: _____ Child's Name: _____ DOB: _____
Parent / Guardian's Name: _____Home Phone #: _____
Cell Phone #: _____ Work Phone #: _____
Address: _____
E-mail Address: _____
Has your child been checked by a Doctor of Chiropractic? □ Yes □ No
If yes, please provide the name of the office & doctor. _____
Were x-rays taken? □ Yes □ No
Who is your medical pediatrician? _____
Has child been treated for any health condition by any physician in the past year? Explain: _____
_____

Prenatal History:

Is your child adopted? □ Yes □ No
Did you have any complications and when? □ Yes □ No
Did you **smoke**? □ Yes □ No
Did you consume **alcohol**? □ Yes □ No
Did you take **medication**? □ Yes □ No
Reason for the medication? _____
Did you experience any **illness(es)** while pregnant? □ Yes □ No
Explain: _____
Did you have **ultrasound** during this pregnancy? □ Yes □ No
What was the frequency? _____

Birth History:

Place of Birth: □ Home □ Birthing Center_____ □ Hospital_____
Provider: □ Midwife_____ □ OB-Gyn_____ □ Other _____
Type of Birth: □ Vaginal □ C-section
Were pain medications used? □ Yes, What? _____ □ No
Was labor induced? □ Yes, How? _____ □ No
If yes, why? _____
How long was your labor from time of your first regular contraction to the birth?_____
How long was the 2nd Stage of labor (the pushing phase) to birth?_____
What position did you deliver in? □ Squatting □ On back □ Other _____
Birth Trauma? □ None □ Doctor assisted □ Twisting and/or Pulling □ Vacuum Extraction □ Forceps

Newborn trauma (medical procedures and tests):

APGAR score: birth ____/10 5-minutes ____/10 □ Unsure
Birth Weight: _____ Birth length: _____
Did your child have a misshaped skull / head? □ Yes □ No
Were there purple markings on their face? □ Yes □ No
Please describe any genetic abnormalities or other disabilities: _____

Newborn/Toddler (Age 0-4 years):

Did you breast feed your child? □ Yes □ No
If yes, how long? _____
Does your child prefer one breast over the other? □ Yes □ No
If yes, which side? □ Right □ Left
Did you formula feed your child? □ Yes □ No

If yes, how long? What type of formula? _____
At what age did you introduce solids? Type? _____
At what age did you introduce cow milk? _____
Does your child have any **food allergies** or **sensitivities**? □ Yes □ No
If yes, please list: _____
Does your child have any **allergies** of any kind? □ Yes □ No
If yes, please explain: _____
Has your child been **immunized**? □ Yes □ No
Vaccination schedule: □ Recommended □ Delayed □ None
Did your child have any negative reaction to the vaccinations? □ Yes □ No
Were they reported? □ Yes □ No
Please list: _____
Has your child ever been ***hospitalized***? □ Yes □ No
If yes, please explain: _____
Has your child ever had any ***surgeries***? □ Yes □ No
If yes, please explain: _____
Has your child been on **antibiotics**? □ Yes □ No
If yes, how often? What for? _____
Is your child currently taking any **medication**? □ Yes □ No
If yes, what are they and use? _____
_____
Is your child currently taking any **vitamins**? □ Yes □ No

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life. (ie: bed, changing table, stairs, etc.) Did this ever happen with your child?
□ Yes □ No
PLEASE EXPLAIN:
_____
_____

Has your child ever been involved in a ***car accident***? □ Yes □ No
If yes, please explain: _____
_____

Has your child had any of the following occur?

□ Tuberculosis	□ Play in a Johnny Jumper	□ Colic	□ (+ or -) weight gain
□ Frequent ear infections	□ Tonsillitis	□ Reaction to vaccines	□ Frequent fevers
□ Frequent diarrhea	□ Constipation	□ Sleeping problems	□ Repeated infections Or colds
□ Whooping cough	□ Eczema	□ Allergies	□ Diabetes
□ Cold sores	□ Measles	□ Mumps	□ Rubella
□ Pneumonia	□ Chicken pox	□ Polio	□ Hypoglycemia
□ Epilepsy	□ Stroke	□ Multiple Sclerosis	□ Hand foot & Mouth

□ Other (Please Explain): _____
_____

Child (5-12):

Have any of the following occurred?

□ Fall from a tree	□ Fall off of a bicycle	□ Sports accident	□ Car accident
□ Stomach pains	□ Scoliosis	□ Bed wetting	□ Fall on playground
□ Hyperactivity / Autism	□ Learning difficulties	□ Asthma	□ Allergies
□ Leg / Knee pains	□ Other (Please explain): _____		

_____

Which of the above bothers your child the most? _____
When did it begin? _____
Is it getting worse? □ Yes □ No
Is the pain: □ Constant □ Intermit □ Cyclical
Effect on activity? □ Always □ Somewhat □ Not at all
Does your child participate in any of the following?

□ Soccer	□ Football	□ Gymnastics	□ Karate	□ Hockey
□ Skiing	□ Basketball	□ Dance	□ Wrestling	□ Baseball / Softball
□ Volleyball	□ Tennis	□ Swimming	□ Rugby	□ Other

How would you rate your child's diet?
□ Well balanced □ Average □ High sugar / processed foods
Does your child consume artificial sweeteners? □ Yes □ No
Does your child consume caffeine? □ Yes □ No
Fluoridated water? □ Yes □ No
Number of hours your child sleeps? _____hours per day
Sleep Quality? □ Good □ Fair □ Poor
What percentage of time during the day (at home or at school) does child spend:
lifting_____ sitting_____ bending_____ working at a computer_____ using electronics _____ TV _____
Has your child missed any school due to condition? □ Yes □ No

Review of Systems:

Check any of the following symptoms the child has **Now (N)** or had in the **Past (P):**

N	P	**General**
___	___	Severe or frequent headaches
___	___	Sinus Infections
___	___	Frequent Colds
___	___	Depression
___	___	Loss of Sleep
___	___	Loss of Weight
___	___	Nervousness
___	___	Tremors
___	___	Arthritis
___	___	Bursitis
___	___	Dizziness
		Pain/Numbness in:
___	___	Neck
___	___	Upper Back
___	___	Shoulders
___	___	Elbows
___	___	Hands
___	___	Lower Back
___	___	Hips
___	___	Legs
___	___	Knees
___	___	Feet
___	___	Sciatica (down back of leg)
		Gastro-Intestinal
___	___	Belching/Gas
___	___	Ulcer/Colitis
___	___	Constipation
___	___	Diarrhea
___	___	Liver Trouble

N	P	**Eyes, Ears, Nose, Throat**
___	___	Deafness
___	___	Earache
___	___	Eye Pain
___	___	Hay Fever
___	___	Sore Throat
___	___	Nasal Obstruction
___	___	Hoarseness
___	___	Nosebleeds
		Cardiovascular
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Cold Hand/Feet
___	___	Heart Surgery/Pacemaker
___	___	Rapid/Slow Beating Heart
___	___	Swelling Ankles
___	___	Varicose Veins
		Respiratory
___	___	Chest Pain
___	___	Chronic Cough
___	___	Difficulty Breathing
___	___	Wheezing
		Genito-Urinary
___	___	Bed Wetting
___	___	Blood/Pus in Urine
___	___	Frequent Urination
___	___	Can't Control Urine
___	___	Painful Urination
___	___	Prostate Trouble

___ ___ Gall Bladder Trouble
___ ___ Acid Reflux/Difficult Digestion
___ ___ Jaundice

Skin

___ ___ Bruise Easily
___ ___ Hives or Allergy
___ ___ Itching or Rashes

****

Authorization to treat a Minor

I, _____the undersigning parent/guarding having legal custody/guardianship of (child's name)_____, a minor, do hereby authorize, request, and direct Dr. Haponski and whomever he/she may designate as an assistant to perform in judgment any examination and chiropractic treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Parent/guardian: _____ Signature: _____
Date: _____