

Welcome to Hall Family Chiropractic

Pediatric Intake Form

Please complete fully so we can help your child best.

Child's Legal Name:	Today's Date: ____/____/____
What he/she prefers to be called:	
Address:	City/State/ZIP:
Home Phone:	Parent's Cell Phone:
Birth date: ____/____/____	Age: Social Security #:
Current School:	
Mother's Name:	Father's Name:
Siblings Names and Ages:	
Who may we thank for referring your child?	
Favorite Hobbies or Interests:	

Please select any of the applicable reasons for your pursuing chiropractic care for your child:

- He/she is continuing care from another chiropractor.
- I recently had my spine checked and see the value in a family subluxation check-up.
- I'm concerned about his/her health and am looking for answers.
- He/she has a specific condition that concerns me.

If so, please explain:

I have no idea why we are here. (That's okay, we will take the time to explain what we do).

Is this visit the result of an auto injury? _____. If so, when was it? _____

Do you have family members with similar health concerns? _____. If so, who? _____

Other doctors he/she has seen for this problem: _____

Has he/she ever been diagnosed with cancer? _____. If so, what kind? _____

Surgeries your child has had: _____

Known Allergies: _____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during Lifetime: _____

Number of doses of other prescription medications taken:

During the past 6 months: _____ Total during Lifetime: _____

List any current medications: _____

List any past medications: _____

Does your child have health insurance? _____ Name of company: _____

Policy # _____ Policy holder _____

In order to better understand your child's current level of health, please check any of the following body signals that your child has had or has previously had:

Headaches Postural Imbalances Growing Pains Scoliosis
 Asthma Allergies Ear Infections Seizures
 Digestive Problems Bedwetting PDD/Autism ADD/ADHD

Other: _____

Prenatal History:

Adopted? _____

Complications during pregnancy? _____. If so, please explain: _____

Ultrasounds during pregnancy? _____. If so, how many? _____

Medications/drugs/caffeine during pregnancy? _____. If so, please list type and amount: _____

Cigarette/Alcohol use during pregnancy? _____. If so, please list type and amount: _____

Location of birth: Hospital Birthing Center Home

Birth Intervention: Mother Induced Mother Medicated (Pitocin, etc.)

Forceps Vacuum Extracted

Baby given Medication after delivery; List: _____

Complications during delivery? _____. If so, please explain: _____

Genetic Disorders/Disabilities? _____. If so, please explain: _____

Breast Fed? _____ How long? _____ Formula Fed? _____ How long? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child? _____. Please explain: _____

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? _____. If so, please list: _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

