bellies babies
and beyond
chiropractic

Dr. Beth Hoffman, D.C.

Pediatric Intake Form

Name: ____ Date: _________________________

D/O/B: ______________________ Age: __________ Male or Female (circle)

Address: ____

Parent name: ___________________________ Parent name: _________________________________

Email of Parent: ____

Phone (best contact number): ____

Who were you referred by? ____

Previous Chiropractic care? YES NO Last visit ____________________

Please check the reasons for pursuing chiropractic care for your child:

___He/She is continuing ongoing care from another chiropractor.

___I recently have had chiropractic care and see the value in having my child evaluated.

___I'm concerned about his/her health and I'm looking for answers

___I want to improve my child's health and wellbeing.

___He/She has a specific condition that concerns me. Explain condition or symptom;

____

____

____

____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ total during lifetime: _____

List reasons:

____

____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ total during lifetime: _____

List medications and reason they are used:

____

____

____

____

Birth Weight: ____________ birth length: _______________

Current weight: ___________current length: _____________

Number of hours of sleep at night? ____

Number and lengths of naps? ____

Quality of sleep? Good Fair Poor

List and vitamins or supplements your child takes:

____

____

____

Prenatal History:

Adopted? YES NO

Complications during pregnancy? YES NO

List: ____

Number of Ultrasounds during pregnancy? ______

Medications/drugs used during pregnancy? YES NO

List: ____

Cigarette/Alcohol use during pregnancy? YES NO

Location of birth: Hospital Birthing Center Home

Birth Interventions: mother induced mother medicated caesarian section forceps

vacuum extraction episiotomy baby given medication after delivery

Complications during delivery? YES NO

List: ____

Genetic disorders or disabilities? YES NO List: ____

Breast Fed? YES NO How long? _____________ Formula fed? YES NO How long? ___________

Has your child been immunized? YES NO

Does your child have or have had any rashes or eczema? YES NO

List: ____

Food or other allergies/sensitivities? YES NO

List:

____

____

Has your child fallen head first from a high place during the first year of life (a bed, changing table, or stairs)? YES NO
List: ____

Has your child been involved in any motor vehicle accidents? YES NO

List: ____

Has your child been involved in any high impact or contact sports? Yes NO

List: _______________________________________ ____

Has your child been seen in the emergency room? YES NO

List: ____

Prior surgery? YES NO List: ____

At what age did your child?

Hold head up ________ walk alone________ stand________ follow things with eyes________

Crawl_______ respond to sound________ sit unassisted_______

Authorization for care of a minor

I hereby authorize this office and its doctors to provide an evaluation on my child and administer care as they so deem necessary to my child (upon approval of parent or guardian).

Sign:____

Date: ______________________

Witness: ____