bellies babies and beyond
chiropractic

Dr. Beth Hoffman, D.C.

Pediatric Intake Form

Name: _____ Date: _____

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

Address: _____

Mothers name: _____ Fathers 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: _____