Gardner Chiropractic:
Family and Wellness Center, PLLC
www.drgardnerchiro.com

3000 Joe DiMaggio Blvd, Unit 54
Round Rock, TX 78665

Pediatric Intake Form

WELCOME,

It is a pleasure to welcome you to our office. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Phone(H)_____ Phone(C)_____
Date of Birth_____ Age_____ Sex M F
Contact Email: _____
Names of Parents/Guardians: _____
IF there are any symptoms or condition, what are they and how are they affecting your child or family?
_____
_____

Other doctor's seen for this condition: Y N
If so, doctor's names & prior treatment: _____
Does your child have any health problems?_____
Family history: _____
Previous chiropractor: _____ Date of last visit: _____
Name of pediatrician: _____
Date of last visit: _____ Reason: _____
Are you satisfied with the care your child has received there? Y N
Number of doses of anitbiotics your child has taken:
During the past 6 months: _____ Total during lifetime: _____
Names of medications: _____
Vaccination history: _____

Current Condition:

Area of concern:_____
When did it start:_____
What makes it worse?_____
What makes it better?_____
Type of feeling (Circle all that Apply): **Dull** **Achy** **Stiff** **Sharp** **Burning** **Stabbing** **Numbness** **Tingling** **Pins & Needles**
Pain Scale (0=None, 10=Worst Ever) _____
Consulted other doctors for this condition? Yes No **Who?**_____
Results?_____
Does this interfere with your_____? **School** **Sleep** **Recreation** **Daily Routine**

Birth History:

Birth weight?_____ Birth length?_____
What was your child's birth like? _____
How long was the entire labor? _____
How long did you actually push? _____
Were you induced? Y N Nerve block? Y N C-section? Y N
Was there any pulling on the head? Y N Forceps or vacuum extraction used? Y N

Feeding History:

Breastfed: Y N How long? _____
Formula fed: Y N How long? _____ Type? _____
Introduced solids at _____ months, cows milk at _____ months.
Food/juice allergies or intolerances: Y N List: _____

First Menses: **Y N** Age: _____

Childhood Diseases: (Please check all that apply)

_____ Chicken Pox Age: _____
_____ Rubella Age: _____
_____ Rubeola Age: _____
_____ Mumps Age: _____
_____ Whooping Cough Age: _____
_____ Other: _____

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Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interferences). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimulus
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the national safety council, approximately 50% of children fall 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? **Y N**
When was your child's most recent fall? _____
Was there any care given? **Y N** Checked by a chiropractor? **Y N**
Is / has your child been involved in any high impact of contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? **Y N**
List:_____
_____
Is / has your child ever been involved in a car accident? **Y N**
List:_____
_____
Has your child been seen on an emergency basis? **Y N**
List:_____
_____
Other traumas not described above? **Y N**
List:_____
_____
Prior surgery:
List:_____
_____

Lifestyle:

What sports or recreational activities does he/she do? _____
_____
Does he/she have any stress either at school or at home? Y N
If yes, please describe: _____
_____
What does there diet include? _____
_____
How is school going?
□ Having Trouble □ Average □ Good □ Excellent
□ Always Absent □ Few Absences □No Absences

We are here to serve you and encourage you to ask questions. You participation is vital and will help determine your results.

Authorization for care of minor

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

_____ _____
Signature Date