166 W. Main Street
Honeoye Falls, NY 14472
Phone: (585) 624-8181/ Fax: (585) 624-8190

Pediatric Intake Form – Birth to 12 Years

Date: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian's Names: _____

Address: _____ City: _____ State: _____

Zip: _____ Email: _____

Home Phone: _____ Is it ok to leave a detailed message? ☐ Yes ☐ No
Cell: _____ Is it ok to leave a detailed message? ☐ Yes ☐ No
Work:_____ Is it ok to leave a detailed message? ☐ Yes ☐ No

Has your child been seen by a chiropractor before? ☐ Yes ☐ No

Has your child had X-Rays taken? ☐ Yes ☐ No If yes, what for? _____

Who is your medical pediatrician? _____ Phone number: _____

Child's Current Height: _____ Child's Current Weight:_____

Prenatal History

Birth weight: _____ Birth Length: _____

Type of Birth: ☐ Vaginal ☐ Breech ☐ Cesarean ☐ Other:

☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Mid- Wife ☐ OB-Gyn ☐ Other: _____

Any medications used during delivery? _____

Was labor induced? ☐ Yes ☐ No If yes, why? _____

Any problems during pregnancy and/or labor?_____
_____

What position did you deliver in? _____
Birth Trauma: ☐ Fractures ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps
☐ Other _____

APGAR Scores: _____ (1 min) _____ (5 min)

Jaundice (yellow) at birth? ☐ Yes ☐ No Cyanosis (blue)? ☐ Yes ☐ No
Birth defects/Abnormalities _____

Do you/Did you breastfeed your child? ☐ Yes ☐ No If yes, for how long? _____

Does your child prefer one breast/side over the other? ☐ Yes ☐ No ☐ Right ☐ Left

Does your child have any food or other allergies or sensitivities? ☐ Yes ☐ No
If yes, please list: _____

Has your child had any surgeries? ☐ Yes ☐ No Please explain:

Have they been on antibiotics? ☐ Yes ☐ No
How many times? _____ Reason: _____

Current Medications: _____

Current Vitamins/Supplements: _____

Developmental History – At what age did the following occur:

Respond to sound _____
Crawl _____
Follow object with eyes _____
Hold head up _____
Stand _____
Sit alone _____
Walk alone _____

Chicken pox _____
Rubella _____
Rubeola _____
Whooping cough _____
Mumps _____
Measles _____
Other _____

Has the child ever suffered from (please check all that apply):

☐ Allergies	☐ Anemia	☐ Arm Problems
☐ Arthritis	☐ Asthma	☐ Backaches
☐ Bed Wetting	☐ Behavior Problem	☐ Blood Disorder
☐ Broken Bones	☐ Colds/Flu	☐ Colic
☐ Crying Spells	☐ Diabetes	☐ Diarrhea
☐ Digestive Issues	☐ Dizziness	☐ Chronic Earaches
☐ Fainting	☐ Falls	☐ "Growing Pains"
☐ Headaches	☐ Heart Trouble	☐ Hyperactivity
☐ Joint Problems	☐ Leg Problems	☐ Low weight
☐ Muscle Jerking	☐ Neck Problems	☐ Neuritis
☐ Orthopedic	☐ Paralysis	☐ Paralysis
☐ Rheumatic Fever	☐ Ruptures/Hernias	☐ Sinus Trouble
☐ Sleeping Problems	☐ Stomach Aches	☐ Sugar Concentration
☐ Tonsillitis	☐ Tuberculosis	☐ Walking Problems
☐ Other:		

Relevant family history: _____

What brings your child in today? _____

When did it begin? _____ Is it getting worse? ☐ Yes ☐ No

Does the complaint affect daily activities? ☐ Not at all ☐ Somewhat ☐ Frequently
☐ Always

What makes it better? _____
What makes is worse? _____
Does it happen at any specific time of the day? _____

List any other care your child has undergone with regards to this complaint including medication: _____
_____

What sports does your child play? _____

How would you rate your child's diet? ☐ Well Balanced ☐ Average ☐ Poor

How much water does your child drink? _____ glasses/ day

Does your child consume artificial sweeteners? ☐ Yes ☐ No

# of hours your child sleeps: _____ Quality: ☐ Good ☐ Fair ☐ Poor

Is there anything else we should know about your child? _____
_____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. April Morsch and whomever she may designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Parent/Guardian Printed Name: _____ Date: _____
Signature: _____

Insurance

Insured's Name: _____ Date of Birth: _____

SS#: _____ Relationship to patient: _____

Insured's Employer: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Assignment and Release: I certify that I, and/or my dependent(s), have coverage with above insurance company and assign directly to Dr. April Morsch all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature _____