Morsch Family Chiropractic

166 West Main ST

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: _____ Chicken pox: _____ Crawl:_____ Rubella:_____ Follow object with eyes: _____
Rubeola: _____ Hold head up: _____ Whooping cough: _____ Stand:_____ Mumps:_____ Sit alone:_____ Measles:_____

Walk alone:_____ 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 do your child play? _____

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

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

Does your child consume artificial sweeteners? ☐ Yes ☐ No

How many hours does your child sleep: _____ 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: _____

Financial Responsibility

Our financial policy has been set up to prevent misunderstandings:

1. Full payment is expected at the time of service.
2. If an appointment is cancelled within 24 hours or missed, a charge of $40 will be applied to your account. We understand that emergencies will come up out of your control. But please understand that your missed appointment is a loss to both our office, and another patient in need of care.
3. Returned checks are subject to a service charge and will terminate your privilege to pay by check at any future visits.
4. It is understood and agreed that in the event that any outstanding balance has to be referred to a collections agency or attorney for recovery. Additionally, you will be fully responsible for any and all legal fees involved.

Parent/Guardian Printed Name: _____ Date: _____

Patient/Guardian Signature: _____