PEDIATRIC INTAKE FORM (3-10 YEAR S)

Name (first, middle,last)_	Date: E-Mail Address:						
Phone Number:							
Address		City	State	Zip			
Date of Birth:				•			
		RelationshipPhone					
Name of Insured:		Birthda	te:	SSN:			
How did you hear about or	ur clinic?			Have			
you ever had chiropractic o							
	REASO	N FOR	VISIT				
Please circle all that ap	ply:						
Wellness/Preventative Care		Poor Posture	Impr	oved athletic performance			
Area(s) of complaint/Conce	rn:						
When did the problem start							
Was this related to a fall or							
Describe the pain/problem:							
If any of the following condition any of the following condition do not apply.							
Headaches	Diarrhea	_	_Neck pain	Nausea			
Ear infections	Constipation	_	Mid back pain	Loss of appetite			
Allergies (seasonal)	Bed-wetting	_	Low back pain	Frequent urinati			
Allergies (food/other)	Colic	_	Knee pain	Frequent thirst Pain in leg			
Sinusitis	Asthma	-	Ankle sprains				
Hyperactivity	Indigestion	_	Fatigue	Mood disorder			
Difficulty sleeping	Learning Diffic	ulties/delays _	Eczema	Skin Issues			
Sleep: Goo	nd Ba-i	Da.					
Current Medications (including	od Bad	Poor					

HEALTH HISTORY

Birth:								
Was the birth assisted?	Y	N						
If yes, how? Forceps	Vac	uum E	xtraction		C-Sec	tion	induced Labor	
Duration of Birth:				ry norm	al?	Yes	No	
Any complications at birth?								
Did your child receive vaccinat		Yes	No	If yes,	which o	nes?	· · · · · · · · · · · · · · · · · · ·	
Did your child react to them?	Yes	No						
Development:								
Does or did your child have an	y of the f	ollowing	g (Please	check a	all that a	pply):		
Difficulty with crawling	ng (on all	fours,	scoot, arr	ny craw	l)			
Difficulty learning to	ride a bil	ke			App	ears clun	nsv	
Difficulty learning to read						culty writi	_	
Difficulty using utensils						-	oning clothing	
Difficulty tying shoes					Difficult or awkward to walk/run			
Poor hand-eye coordination				_		ng or paying attention		
Skipped milestone:	Roll, Sit,	Crawl,	Stand, or	Walk	_	•	. , ,	
At what age did	i your cl	nild sta	rt to wall	c unass	isted: _			
Neurological/Other:								
Has your child ever been diagn	osed by	a medi	cal profes	sional w	vith any	of the foll	owing:	
Hearing loss or impairr	nent				Visual	Impairme	ent	
Neurological disorders					Anxiety/Depression			
Obsessive Compulsive Disorder				Autism/Autism Spectrum Disorder				
ADD/ADHD					Tourett	te's Synd	rome	
Dyslexia								
If yes, by who	om?							
2 1 1 1 1 1 1 1 1 1 1								
General Activities (Check al	II that app	oly):						
heavy backpack (more than	1 15% of	body w	eight)		sle	eps on st	omach	
plays video games hours/day					exercise hours/day			
soft drinks drinks/day					cor	mputer/ipa	ad use hours/day	
List any sports/recreational acti	vities:							
Do you have any pets at home		Υ	N					
Food:								
Approximate consumption per of Favorite foods list:							oda/Other	
Is your child a picky eater?		N						
If yes, describe:								

CONSENT TO EXAMINE, X -RAY, AND TREAT A MINOR

I, the parent or legal representative of	authorizo tho
performance of a diagnostic examination and x-rays of may consider necessary or advisable in the course of tr	this child or which Druzbik Family Chiropractic
Parent/Guardian Signature	
HIPAA (HEALTH INSURANCE PORTA	
Dr. Druzbik and members of the practice staff may need your clinical records to contact you with appointment alternatives or other health related information that may phone and you are not at home a message will be less member. By signing this form, you are giving us author information	ent reminders, information about treatment ay be of interest to you. If this contact is made by ft on your answering machine or with a family ization to contact you with these reminders and
You can restrict the individuals or organizations to whice may revoke your authorization to us at any time, how mailed to us at our office address. We will not be able already released your health information before we recommend in addition, if you were required to give your authorizations.	wever your revocation must be in writing and e to honor your revocation request if we have seive your request to revoke your authorization. ation as a condition of obtaining insurance, the
Information that we use or disclose based on author disclosure by anyone who has access to the reminde protected by the feder	er or other information and may no longer be
You have the right to refuse to give us this authorizatio affect the treatment we provide to you or the methods	n. If you do not give us authorization, it will not we use to obtain reimbursement for your care.
You may inspect or copy the information that we use reminders, information about treatment alternatives, of (#164.524). This notice is effective as ofseven years after the date in which you	or other health related information at any time, 20 . This authorization will expire
I authorize you to use or disclose my health information understand that I may receive a copy of this form when i	in the manner described above. I also needed.
Patient (Guardian) Signature	Date