WELCOME TO INNATE FAMILY CHIROPRACTIC!

Please fill out this form as completely and accurately as possible.

All the information requested below is necessary for us to serve you the best way possible.

Pediatric Intake Form

Personal Information

Patient name____ Date of Birth_________________________________

Parent's names ____

Address ________________________________ City__________________________ Zip _____________________

Home phone (____) ____________________ Email ____

Occupation__________________________ Employer ____

Employer Address___________________________ City __________________________ Zip ________________

Business Phone(____)________________________ Date of birth __________________________________

Whom may we thank for your referral? ____________________________

What concerns do you feel Innate Family Chiropractic can address for you?__________________________________

____

____

Has your child ever received chiropractic care? Y N If yes, with whom?_____________________________________

Date of last visit ____________ Why did you stop care? ____

Was there a particular health concern for which you consulted the chiropractor? ______________________________

____

Pediatrician_______________________________ Dates seen ____

Your Child's Health Profile

Please mark an "X" for current condition or an "O" for past condition.

___Ear infections	___Scoliosis	___Seizures	___Chronic colds
___Headaches	___Asthma	___Allergies	___Digestive problem
___ADHD	___Bedwetting	___Colic	___Acid reflux
___Behavioral problems	___Bowel problems	___Poor appetite	___Difficulty crawling
___Difficulty walking	___Other (please describe) ____		

Number of antibiotics your child has been prescribed ____

Please list any current medications or drugs____

Vaccination history (Circle one) Up to date Chose to decline vaccines Still deciding

Please describe any adverse reactions to medications, vaccinations or sugeries ______________________________

____

I would like more information regarding vaccinations (Circle) Yes No Maybe

Please list any current vitamins, supplements, herbs, homeopathic, etc_____________________________________

____

Chiropractic, Your Nervous System, & Life

The human body is designed to be healthy.

The primary system in the body which coordinates health is the NERVOUS SYSTEM.

The bones of the spine, called vertebrae, surround and protect the delicate NERVOUS SYSTEM.
Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate NERVOUS SYSTEM. The result is a condition called a Vertebral Subluxation. The chiropractic exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process. Physical, chemical, and emotional issues may cause Vertbebral Subluxations in your child's spine. The remainder of the intake form addresses the possible situations that may cause Vertebral Subluxation in your child's spine.

Physical Causes:

Birth history

Name of Obstetrician / Midwife ____

Pregnancy or Birth Complications (circle) Yes No If yes, please explain____

____

____

Birth Intervention (circle) Forceps Vacuum Extraction Cesarean Induction External Cephalic Version

Birth until now

At what age was your child able to do the following:

___Respond to sounds ___Hold head up ___Sit up ___Crawl

___Stand ___Walk ___Speaking words ___Conversing

Has your child had any of the following:

___Automobile accident ___Bicycle accident ___Sports injury ___Serious falls

___Difficulty crawling ___Difficulty walking ___Broken bones ___Difficulty nursing

___Hospitalizations

If yes to any above, please list date and explain____

____

Chemical Causes:

Was your child breastfed or formula fed?________________________ How long?___________________________________

Age when solids were introduced_______ Age when milk was introduced and what kind of milk (circle)_______________

Cow's milk Goat's milk Almond Milk Other

Food/drink intolerances, allergies, or sensitivities ____

____

Has your child been exposed to any of the following on a regular basis?

___Toxic chemicals ___Drugs (prescribed or not) ___Second hand smoke ___Other

Does your child take a probiotic supplement? Yes No

Does your child take a fish oil supplement? Yes No

Does your child ingest sugar in the form of candies, sweets, or soda? Yes No

Does your child ingest artificial sweeteners like Splenda or diet sodas? Yes No

Does your child ingest cereals, white breads, and pastas? Yes No

Emotional Causes:

Please indicate if your child has experienced any of the following emotional stresses in their life.

___Physical trauma ___Loss of loved one or pet ___Abuse ___Work or school stress

___Parents divorce/separation ___Lifestyle change ___Illness

Does your child have difficulty concentrating? Yes No

Does your child complain of having headaches and feeling overwhelmed? Yes No

Does your child throw temper tantrums? Yes No

Is your child confident in social settings? Yes No

Thank you for choosing Innate Family Chiropractic.

We look forward to helping you and your family live at your full potential!

Consent to Care

When a person seeks Chiropractic care, and we accept a person for care, it is essential for both to be working towards the same goals. Chiropractic has a specific goal to remove subluxation (nerve interference) from the spine. Removing subluxation through specific adjustments allows the body to function at its optimal potential. The three causes of subluxation are physical stress, chemical stress, and emotional stress.

Our focus in this office is checking the spine for vertebral subluxation, giving specific adjustments when necessary, and promoting optimal function for each individual we take care of. We do not offer to diagnose or treat disease. However, if we encounter non-chiropractic or unusual findings we will inform you. If you desire advice, diagnosis or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our practice objective is to locate, analyze and correct subluxation through specific adjustments while helping individuals, couples, and families live at their full potential.

I, ____________________________ have read and fully understand the above statements.
(Print Name)

All questions regarding the chiropractor's objective to my care in her office have been answered to my complete satisfaction. I therefore accept care on this basis.

____

Signature **Date**

X-RAY Questionnaire: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

- ☐ **There is a possibility that I may be pregnant at this time**
- ☐ **Yes, I am definitely pregnant**
- ☐ **No, I am definitely not pregnant at this time**
- ☐ **I request x-ray films not be taken because ___________________Date of last menstrual period____________**

____

Signature **Date**

Consent to Evaluate and adjust a Minor Child

I ____________________________________ being the parent or legal guardian of _________________________________
Have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

____

Signature **Date**