FIRESTONE
CHIROPRACTIC & WELLNESS

400 W Cummings Park
Suite 5450
Woburn, MA 01801

Tel: 781-281-1086
Fax: 781-281-1843
info@firestonechiroandwellness.com

Pediatric Intake Form

Confidential Child's Health Information

Child's Name: _____

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell Phone: _____ Email: _____

D.O.B.: _____/_____/_____ Age: _____ SSN:_____/_____/_____

Gender: _____ Height: _____ Weight: _____

Primary Care Physician Name and Phone:_____

Has the child been to a Chiropractor before? ☐Y ☐N Experience: ☐Positive ☐Negative

How did you hear about us? _____

Condition Information

Please describe your child's complaints/current condition and any symptoms that he/she is experiencing

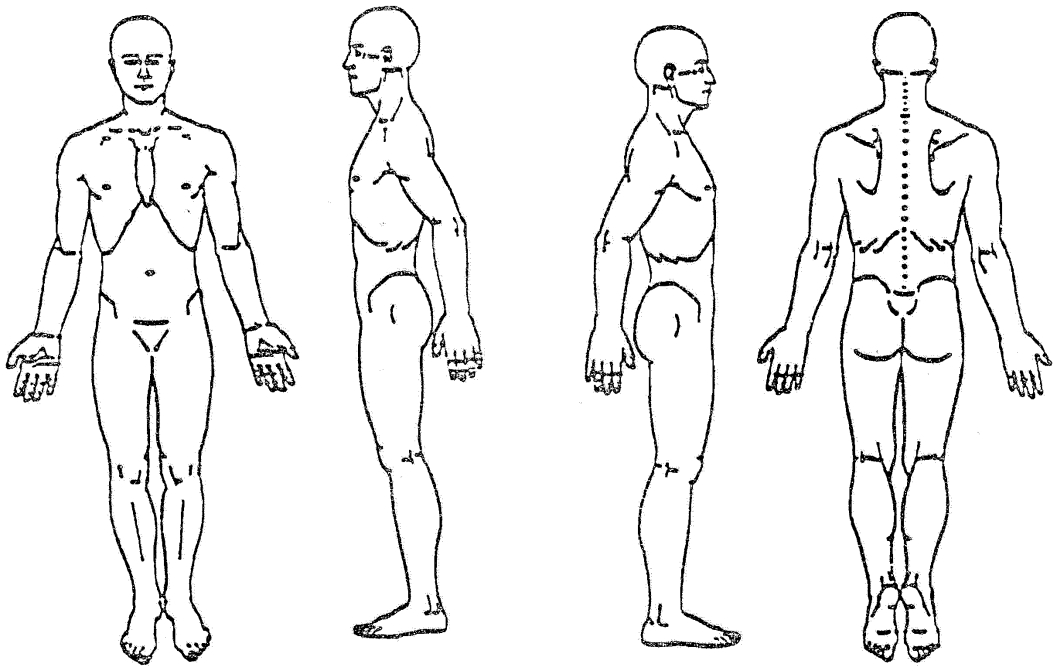
_____

_____

_____

_____

If applicable, please mark the areas of complaint



Left Side Right Side

Aching.....A
Dull.....D
Sharp.....SP
Shooting.....SH
Stabbing.....ST
Burning.....B
Numbness.....N
Tingling.....T

How long has the child had this condition? _____

How did the condition start?_____

What aggravates it?_____

What relieves it? _____

Does it radiate? ☐Y ☐N If so, where does it travel?_____

Has your child had similar conditions in the past? ☐Y ☐N

How frequently does your child experience this type of condition?

☐Constantly 76-100% ☐Frequently 51-75% ☐Occasionally 26-50% ☐Rarely 0-25%

Is the condition changing? ☐Getting better ☐Getting Worse ☐Unchanged

Is your child's sleep interrupted? ☐Y ☐N Changes in eating habits? ☐Y ☐N

Have your child seen any other health care provider for this problem? ☐Y ☐N

If Yes, which health care provider? _____

Results of the treatment: _____

Family History

Please indicate if any of the following apply to your child (currently or in the past) or your immediate family members. (C = Currently P = Past F = Family Members)

___ Alcoholism
___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Bleeding/Bruising
___ Blood Pressure – Hi or Low
___ Bursitis
___ Cancer
___ Cardiac Issues
___ Circulation Issues
___ Contact Lenses
___ Dementia
___ Depression
___ Diabetes
___ Digestive Issues
___ Dizziness/Fainting
___ Endocrine Issues
___ Epilepsy
___ Fibromyalgia
___ Headaches
___ Heart Disease
___ Hernia
___ High Cholesterol
___ Joint Problems
___ Kidney/Urinary
___ Liver/Gall Bladder
___ Multiple Sclerosis
___ Muscle Strain/Sprain
___ Neurological Issues
___ Osteoporosis
___ Pacemaker
___ Phlebitis/Blood Clots
___ Respiratory Issues
___ Seizures/Epilepsy
___ Sinus Issues
___ Skin Conditions
___ Stress
___ Stroke
___ Trauma
___ Tumors
___ Ulcers
___ Varicose Veins
___ Vertebral/Disc Problems
___ Other
_____
_____

History of Birth

Where was the child's birth? ☐Home ☐Hospital ☐Other _____

Who was on your birth team? (Please check all that apply) ☐OB/GYN ☐NP ☐RN ☐Midwife ☐Doula

Labor was: ☐Spontaneous ☐Induced

Was medication or an epidural given to the mother during birth? ☐Y ☐N If yes, what was given?

_____

Was there any assistance used during birth? ☐Forceps ☐ Vacuum ☐C-Section

What was the duration of the labor and delivery? _____

What was the child's gestational age at birth? _____ weeks

Were there any complications? ☐Y ☐N If so, please explain:

_____

Any traumas to the mother during pregnancy? (ie, falls, accidents, etc.) ☐Y ☐N If yes, please explain:

_____

Any evidence of birth trauma to the infant? (Please check all that apply)

☐Bruising	☐ Stuck in birth canal	☐Respiratory depression
☐Misshaped head	☐Fast or excessively long birth	☐Cord around neck

Growth and Development

Was the child breast fed? ☐Y ☐N If yes, how long? _____

Any difficulty with lactation or baby's latch? ☐Y ☐N

Was formula introduced? ☐Y ☐N If so, at what age? _____

When was the introduction to cow's milk? _____

When did your child begin eating solid foods? _____

Have you noticed any food/juice intolerance? ☐Y ☐N If yes, to what?

_____

At what age did the child:

Respond to sound: _____ Hold head up: _____ Sit alone: _____

Crawl: _____ Follow an object: _____ Vocalize: _____

Teethe: _____ Walk: _____

Do you consider the child's sleeping pattern normal? ☐Y ☐N If no, please explain

_____

How long does/did your child exercise tummy time? _____

Has the child had any falls from the couch, beds, changing tables, etc? ☐Y ☐N If yes, please explain

_____

Has the child had any traumas resulting in bruises, cuts, stitches or fractures? ☐Y ☐N If yes, please explain _____

Has the child had any hospitalizations or surgeries? ☐Y ☐N If yes, please explain

_____

Is your child experiencing any of the following? (Please check all that apply)

☐ Bed wetting ☐ Behavioral problems ☐ Difficulty sleeping
☐ Night terrors ☐ Sleep walking

Do you feel that your child's social and emotional development is normal for their age?

_____

_____

Consent and Policies Agreement

Please read the statements below and initial them to confirm that you have read and understood them. If you have any questions, please ask.

_____ I grant permission to Firestone Chiropractic & Wellness to perform diagnostic testing and rendering of Chiropractic, Nutrition Counseling, and Massage Therapy services to the child mentioned below.

_____ I authorize Firestone Chiropractic & Wellness to collect the child's personal and medical information as documented above. This information is confidential and will not be disclosed to 3rd parties without my consent. I give permission for Firestone Chiropractic & Wellness to contact me and leave a message at any of the above telephone numbers.

_____ Firestone Chiropractic & Wellness maintains a professional environment and therefore reserves the right to cancel or terminate any session in the event the client's behavior is considered inappropriate. Payment for the service will be rendered in full. Termination of the session is at the discretion of the Doctor or therapist and does not require an explanation.

_____ I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that the child should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage should not be performed under certain medical conditions, I affirm that I have stated all the known medical conditions of the child, and answered all questions honestly.

_____ Appointment Cancellation Policy: Please provide us 24-hour advance notice when cancelling an appointment, except in the case of emergency or sudden illness. Cancellations or missed appointments without 24-hour notice will result in a full charge for the appointment or session. **For Chiropractic appointments, the fee is based on the private pay rate of the appointment. For massage and nutrition appointments, the fee is the full amount of the appointment.**

I have read the above statements and understand the policies of Firestone Chiropractic & Wellness.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date: _____/_____/_____

Minor Name _____

Minor DOB: _____/_____/_____

In addition, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed Name of alternate Parent/Guardian:_____

Relationship to Patient: _____