Bermuda Chiropractic Health Center

Pedriatric Chiropractic Intake Form

CONTACT INFORMATION:

Name: ____ Today's Date: _________________________-
Sex: Male Female Date of Birth: _______________ Name of Parents/Guardian__________________________________
Address: ____
Home Phone: ____________________ Work Phone: ________________________ Cell Phone: ___________________
Email: ____ Emergency Contact: __________________________________

INSURANCE DETAILS:

Insurance Co. _______________________________ Group #__________________________ Cert. #____________________
Subscriber's Name________________________________ Subscriber's DOB:_______________________________________
Whom may we thank for referring you? ____

Authorization to Treat a Minor

I, _______________________________ the undersigning parent/guardian having legal custody/guardianship of ____________________________________, a minor, do hereby authorize, request and direct AIIH/Bermuda Chiropractic Health Center and whomever we might designate to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

As specific written authorization you provide may be revoke at any time by writing to us at 44 Point Finger Rd. Paget DV04. Email: office@aiih.net

Patient: _______________________________________ Signature ______________________________________
Print Name Parent/Legal Guardian

REASON FOR VISIT:

Goals for Care: Resolve Condition ( ) Improve General Wellness ( ) Both ( )
Present Complaint: ____
When did this begin? ______________________________ Was there an accident or injury involved? ( ) Yes ( ) No
Is Condition: Getting worse❑ Getting Better ❑ Not Changing ❑Intermittent ❑Constant
Nature of Symptoms: ❑ Sharp ❑ Dull Ache ❑ Shooting ❑Burning ❑Tingling ❑Numb
Condition is affected by what activity? ____
Has your child had any past treatment for this complaint? ( ) yes ( ) No Explain _____________________________
Other Doctor's/Therapist/Chiropractors Yes ( ) Names:____
Diagnosis Provided: ____

PRENATAL & FERTILITY HISTORY: Please tell us about the pregnancy

PRENATAL/FERTILITY HISTORY

Prior Miscarriages ( ) Yes .No How Many? ____ ( ) No Age of Parents: ____Explain:_____________________________
Any Complications during Pregnancy? ( ) Yes ( ) No Explain: ____
Medications taken during Pregnancy: _______________ Prenatal Vitamins ❑ Supplements ❑ _____________________
During Pregnancy: Stress ❑ Caffeine ❑ Alcohol ❑Cigarettes ❑ Exercise ❑ Ultrasounds ❑ Illness ❑
Other ❑ Explain:____

LABOUR & DELIVERY HISTORY

At how many weeks of pregnancy was child was born? _______ Weeks
Birth/ Interventions: ( ) Forceps ( ) Vacuum ( ) C-Section ( ) Medication ( ) Vaginal ( ) Other: _________________
Complications during Delivery? ( ) Yes ( ) No Explain____
Genetic disorders: ❑ Disabilities ❑ Infections ❑Jaundice ❑ Other: ____
Any problems at birth with: ❑ Appearance ❑ Pulse ❑Grimace Response ❑ Activity (Muscle Tone) ❑Respiration
If known, Child's Birth weight: __lbs. __oz.__ Height __inches. APGAR SCORE Birth___ APGAR SCORE after 5 Min. ___

FEEDING/NUTRITIONAL HISTORY

Any Difficulty Nursing: No ( ) Yes ( )
Breast Fed ( ) Formula Fed Age Formula introduced __. ( ) Nursed for How Long: ________
Introduced to: solids at ___ Months, Cow's Milk at ____ Months
Food Allergies or intolerances: ( ) Yes ( ) No List: ____
How would you rate your child's diet? ( ) Well Balance ( ) Average ( ) Picky eater ( ) Other ___________________
Rate your child's consumption of Artificial sweeteners and Processed Foot: ❑ None ❑ Rare ❑Occasional ❑ Often

MEDICAL SURVEY

How many times has your child been prescribed antibiotics in the past 6 months? ____ Total during lifetime: _________
Has your child received vaccinations? ( ) Yes ( ) No; Complications ( ) Yes ( ) No Explain:________________________

CHILDHOOD DISEASES:

Chicken Pox:	( ) Yes ( ) No	Rubella:	( ) Yes ( ) No
Rebeola:	( ) Yes ( ) No	Mumps:	( ) Yes ( ) No
Whooping Cough	( ) Yes ( ) No Age___	Whooping Cough	( ) Yes ( ) No Age___

Other: ________________ Age: ______

GROWTH MILESTONES:

____ Holds up Head (1-2 Months)
____ (3-5 Months)
____ Rolls over/Passes objects from hand to hand (6-8 Months)
____ Sit up alone/pulls to stand (9-11Months)
____ Walks w/Support or Independent (12 Months)
____ Climbs Stairs w/aid uses spoon (18 Months)
____ Kicks Ball/Holds (24 Months)
____ Can Hop on 1 Leg/Refers to self as I (30 Months)
____ Copies a Circle, Dress w/Help can pedal a bicycle
____ Can Hop on 1 Leg/Refers to self as I (30 Months)
____ Walks on Heels/Finger Opposite 1500 words (3-4 Years)
____ (4-5 Years) Stand on 1 leg for 10 sec. Draws a Person.

At what age did your child: Respond to Sound : ___ Follow an object:___ Hold their head up: ___ Vocalize: ___
Sit Alone: ____ Crawl: ___ Walk: ___ Begin cow's mild:___ Begin Solid foods:___

SOCIAL HISTORY

Number of Hours/day your child sleeps? ________ Sleep Quality: ( ) Good ( ) Fair ( ) Poor ( ) Night Terrors
Number of hours/day using TV____ Computer ____ Table or Phone ____ Hrs
Any behavioral, emotional, social or learning concerns? ( ) Yes ( ) No Explain: _______________________________
Did/Does your child have difficulty ( ) Walking ( ) Crawling ( ) Playing Sports ( ) Making Friends ( ) running
( ) Reading ( ) Writing ( ) Math Other: ______________________________
According to National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e: a bed, change table, down stairs, etc.) Was this the case with your child? ( ) Yes ( ) No
Explain: ____
Has your child ever been involved in a car accident? ( ) Yes ( ) No Explain: ______________________________
Other traumas not described above? ( ) yes ( ) No Explain: ______________________ Prior Surgeries? ( ) Yes ( ) No
Does Your child play sports ( ) Yes ( ) No. Explain: ____

FAMILY HISTORY

Is child adopted ( ) Yes ( ) No
Age of Biological Parents: Mother ____ Father ____ Siblings ( ) Yes ( ) No Sibling Names: ___________________________

Health Concerns in Parents/Siblings/Blood Relatives ( ) Yes ( ) No Explain ___________________________

REVIEW OF SYMPTOMS

☐ **GENERAL/IMMUNE**
Weight Changes
Energy Level/Fatigue
Sleep
Growth
Fever
Changes in Appetite
Painful/Swollen Lymph nodes/ Glands
Other:___________________________

☐ **Respiratory**
Chronic Coughs/Colds
Asthma
Other:__________________________

☐ **HEENT**
Headaches
Sinusitus
Other:___________________________

☐**URINARY/GENITO-Reproductive**
Infections/Pain
Increased Frequency
Bedwetting
Puberty Age___
Hernias
Sexual Concerns
Menarche Age__
Menses ___
Other:____________________________

☐**ANY OTHER CONCERNS NOT LISTED**

____
____
____
____

☐ **Gastrointestinal**
Colic
Constipation
Diarrhea
Pain
Reflux
Other:________________________

☐ **Musculoskeletal**
Joint Pain
Postural imbalances
Scoliosis
Hip dysplasia/Disorders
Osteoporosis
Other:________________________

☐ **Cardiovascular**
Heart Abnormalities
Abnormal Breathing
Other:_________________________

☐ **Endocrine**
Hormones Concerns
Sugar Handling
Excessive Appettite
Diabetes
Thyroid
Other:_______________________

☐ **Learning or Behavior:**
Autism
ADD/ADHD/ODD (oppositional Defiance Disorder
PDD Pervasive Development Disorder
Dyslexia
Dysgraphia
Nervousness
Moodiness
Depression
Other:______________________________

☐ **Neurological**
Loss of smell, taste, vision, hearing
Vision-blurred
Balance
Seizures/Tics,
Numbness, Pins and Needles
Other:______________________

☐ **Dermatological**
Skin Disorders
Eczema/Rashes
Other:_______________________

Please put an X on the area of complaint