

Northern Family Chiropractic

13968 Cypress Drive – Suite 1B

Baxter, MN 56425

218.822.3855/218.822.3854

Pediatric Intake (1-4 yrs old)

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Referred by: _____

Date of Birth: _____ Age: _____ Sex: M F (please circle)

Mother's name: _____ Father's Name: _____

Address if different from child: _____ City: _____ State: _____

Phone number/Contact number: _____

Siblings:

Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F

CHIEF COMPLAINT

Reason for visit today: _____

Date of onset: _____ Onset was: (please circle) Sudden Gradual Assoc. w/ an Event

Duration of problem: _____ minutes / hours / days

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Initiating factors: _____

Aggravating factors: _____

Relieving factors: _____

Effects of problems on body function and daily activities: _____

IMMUNIZATIONS

Has the patient been immunized? YES NO Have you noticed any reactions to the vaccination? YES NO

If yes, what have you noticed? _____

GENERAL SYSTEMS REVIEW

Has your child ever been unconscious or had a convulsion? _____

Have you noticed any problems with the eyes, including vision? _____

ILLNESSES

Please list any illnesses: _____

FAMILY PHYSICIAN/PEDIATRICIAN

Name of Pediatrician: _____ Date of last exam: _____

Please list any significant findings: _____

BIRTH PROCESS

Was the delivery: Vaginal or C-Section

Did the pregnancy go full term? YES NO If no, what was the duration of the pregnancy? _____

Circle any of the following which were used during delivery: Fetal monitor Forceps Vacuum Extraction Medications

Were there any problems or significant events during the birthing process? YES NO If yes, what problems did you experience? _____

FAMILY MEDICAL HISTORY

Please check if any blood relative to the patient has or had any of the following illnesses and mark accordingly by noting M (mother), F (father), S (sibling), PGM (paternal grandmother), MGM (maternal grandmother), PGF (paternal grandfather), or MGF (maternal grandfather).

- | | |
|-----------------------------------|--------------------------|
| _____ Allergy, Asthma, or Eczema | _____ Liver Disease |
| _____ Cancer | _____ Mental Retardation |
| _____ Diabetes or low blood sugar | _____ Mental Illness |
| _____ Heart Trouble | _____ Scoliosis |
| _____ High blood pressure | _____ Ulcer |
| _____ Kidney disease | _____ Other: _____ |

ADDITIONAL INFORMATION

Use this space for further information concerning specific items previously checked:

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Erica L Johnson to administer chiropractic care as deemed necessary to my child.

Name of Child

Date

Guardian Signature

Witness Signature