Northern Family Chiropractic

13968 Cypress Drive – Suite 1B

Baxter, MN 56425

218.822.3855/218.822.3854

Pediatric Intake (5-15 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:_____

CHIROPRACTIC HISTORY

Has your child ever received chiropractic care? YES NO

If yes, when:_____ and by whom:_____

Reason for previous chiropractic treatment:_____

ILLNESSES

Please list any illnesses:_____

_____

GENERAL SYSTEMS REVIEW

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

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

Does your child have any gastrointestinal problems including bed wetting, constipation, or indigestion?_____

_____

FAMILY PHYSICAIN/PEDIATRICIAN

Name of Pediatrician:_____ Date of last exam:_____

Please list any significant findings:_____

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

_____ Cancer

_____ Diabetes or low blood sugar

_____ Heart Trouble

_____ High blood pressure

_____ Kidney disease

_____ Liver Disease

_____ Mental Retardation

_____ Mental Illness

_____ Scoliosis

_____ Ulcer

_____ 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