Whom may we thank for referring you to this office → _____?

HEALTH QUEST
CHIROPRACTIC

PEDIATRIC INTAKE FORM FOR CARE AT HEALTH QUEST CHIROPRACTIC

Today's Date: _____ CTN: _____

PATIENT DEMOGRAPHICS

Childs Name: _____ Birth Date: _____-_____-_____ Age: _____ M or F

Address: _____ City: _____ State: _____ Zip: _____

Mothers Name: _____ Fathers Name: _____

Mothers E-mail: _____ Fathers email: _____

Home Phone: _____Mothers Work/Cell: _____ Fathers work/Cell_____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Name & Number of Emergency Contact: _____Relationship: _____

Birth Weight: _____ Current Weight:_____ Birth Length:_____ # of Siblings:_____

Type of Birth (circle all that apply): Normal vaginal Forceps Breech Cesarean

Childs Congenital Anomalies/Defects: _____

Family History of Congenital Anomalies/Defects: _____

Birthing Location: Home Birth or Birthing Center Hospital: _____

Pregnancy History/Problems during Pregnancy: _____
_____

Delivery and Birth History / Problems During Labor and Delivery: _____
_____

APGAR Score: ___ ____ Was there presence of: _____ Jaundice (yellow) _____ Cyanosis (blue)

Infant Feeding: Breast: _____ # of months_____ Bottle: _____ # of Months:_____

Formula: ____# of Months: _____ Brand(s):_____

Number of Hours of Sleep Per Night: _____ Quality of Sleep (circle): Good Fair Poor

Immunization History: _____

Developmental History – At what age did the child:

___ mo/yrs Respond to sound
___ mo/yrs Follow an object with their eyes
___ mo/yrs Hold head up
___ mo/yrs Crawl
___mo/yrs Sit unadided
___ mo/yrs Stand unaided
___ mo/yrs Walk unaided

Childhood Diseases (check all that apply)

___ Chicken Pox ___Mumps
___ Measles ___ Rubella
___ Rubeola ___ Whooping cough
Other:_____

Reason For This Visit:_____

Activities of Daily Living/Symptoms/Medications

Has this child ever suffered from (check all that apply):

___ Diabetes	___ Neuritis	___ Dizziness	___ Anemia	___ Paralysis
___ Poor appetite	___ Frequent Colds/Flu	___ Bed wetting	___ Neck problems	___ Fainting
___ Joint problems	___ Convulsions/Epilepsy	___ Headaches	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Backaches	___ Broken bones	___ Stomach Aches
___ Tuberculosis	___ Hyperactivity	___ Rheumatic Fever	___ Arm problems	___ Leg problems
___ Ruptures/hernia	___ Blood disorders	___ Hypertension	___ Asthma	___ Constipation
___ Diarrhea	___ Allergies	___ Sinus Trouble	___ Walking problems	___ Behavioral problems
___ Muscle jerking	Other: _____			

Present History and Allergies: _____

_____

Surgeries: _____

Accidents: _____

Medications: _____

Family History: _____

I hereby authorize payment to be made directly to Health Quest Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Health Quest Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ CT#: _____ ___/___/___