River City CHIROPRACTIC

Pediatric Healthcare Intake

4311 W 6th Street, Ste C
Lawrence, KS 66049
785-856-0423

ABOUT THE PATIENT (CHILD)

Today's Date_____

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Who may we thank for referring you to our office? _____

Parent A	Parent B
Name _____	Name _____
Cell Phone _____	Cell Phone _____
Other Phone _____	Other Phone _____
Employer _____	Employer _____
Email _____	Email _____

HEALTH CARE PRACTITIONER HISTORY:

Child's Pediatrician/PCP: _____ Office # _____

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child? Check all that apply:

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

_____

REASON FOR SEEKING CHIROPRACTIC CARE:

What concerns do you feel River City Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Check all that apply: (how the concerns affect your child's life)

❑ School ❑ Exercise/Sports ❑ Walking
❑ Playing ❑ Sleep ❑ Attention/Focus
❑ Communication ❑ Eating ❑ Daily Routine

Please describe how the concerns are affecting other aspects of the child's life_____

_____

Number of hours of sleep: _____ Quality of Sleep: ❑ Good ❑ Fair ❑ Poor

Has your child ever been treated on an emergency basis: ❑ Yes ❑ No

If YES, describe: _____

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

The following information will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

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PREGNANCY & BIRTH:

During pregnancy, did the mother:

❑ Experience any significant illnesses, difficulties, or trauma? _____

❑ Take any drugs/medications? _____

❑ Smoke or consume alcohol? _____

Please check all that apply to the patient's birth:

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ❑ No ❑ Yes _____

Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system.

Please check which, if any, of the following were administered during labor and birth:

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____

❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck ❑ Other _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____

❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

CHEMICAL STRESS:

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes

If yes: ❑ Regular Schedule ❑ Delayed Schedule ❑ Alternative Schedule ❑ Yearly Flu Shot

Please describe any and all reactions to vaccine(s)_____

_____

Allergies or Sensitivities to foods? ❑ Yes ❑ No If yes, which ones & reactions: _____

_____

Allergies or Sensitivities to medication? ❑ Yes ❑ No If yes, which ones & reactions: _____

_____

Note: It is imperative that you list all medications as they may have an influence on your child's care.

Name of Medication (OTC/Rx) or Supplement	Dosage	Frequency	Method	Reason for Taking

Has your child been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Mold ❑ Perfume ❑ Scented Candles ❑ Air Freshener/Plug-ins ❑ Drug Therapy

❑ Lotions ❑ Bleach ❑ Beauty Products ❑ Household Cleaning Products ❑ Plastic Use

❑ Antibiotic Use ❑ Nursed ❑ Formula Fed ❑ Recreational Drugs ❑ Dryer Sheets

❑ Caffeine ❑ Soda ❑ Radiation ❑ Secondhand Smoke ❑ Other

Exposure	Frequency	Duration	Exposure	Frequency	Duration

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PHYSICAL STRESS:

Is the reason you are seeking care related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other
Weight of backpack: _____
What physical activities does your child participate in? _____
_____

Childhood Diseases: ❑ Chicken Pox ❑ Measles ❑ Mumps ❑ Rubella ❑ Whooping Cough ❑ Other: _____

Please CHECK ALL THAT APPLY (**current or history of**) and give any necessary details:

❑ 1. Accident Prone/ Uncoordinated	❑ 11. Chronic Illness	❑ 22. Fainting	❑ 33. Neck Problems
	❑ 12. Colds/Flu	❑ 23. "Growing Pains"	❑ 34. Neuritis
❑ 2. Anemia	❑ 13. Concentration Inability	❑ 24. Headaches	❑ 35. Orthopedic Problems
❑ 3. Arm Pain	❑ 14. Constipation	❑ 25. Heart Trouble	❑ 36. Paralysis
❑ 4. Arthritis	❑ 15. Convulsions	❑ 26. Hospitalizations	❑ 37. Poor Appetite
❑ 5. Asthma	❑ 16. Diabetes	❑ 27. Hyperactivity	❑ 38. Rheumatic Fever
❑ 6. Auto Accident	❑ 17. Diarrhea	❑ 28. Hypertension	❑ 39. Ruptures/Hernias
❑ 7. Backaches	❑ 18. Digestive Disorders	❑ 29. Joint Problems	❑ 40. Sinus Issues
❑ 8. Bed Wetting	❑ 19. Dizziness	❑ 30. Muscle Jerking	❑ 41. Surgery
❑ 9. Behavior Problems	❑ 20. Ear Aches	❑ 31. Muscle Pain	❑ 42. Severe Trauma
❑ 10. Broken Bones	❑ 21. Ear Infection	❑ 32. Muscle Tightness	❑ 43. Other

Give Details, mention # of problems listed above: _____
_____
_____
_____
_____
_____

EMOTIONAL STRESS:

It is difficult to separate the emotional stress in our life from the physical response that often occurs.
Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic Pressure	❑ Loss of a Loved One	❑ Bullying	❑ Relocation
❑ Lifestyle Change	❑ Parents' Divorce	❑ Loss of a Pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

EXPECTATIONS OF CARE:

I would like my child to experience the following benefits from Chiropractic Care (check all that apply):

❑ Symptomatic relief of pain or discomfort ❑ Optimal health on all levels
❑ Prevention of future problems ❑ Healthier spine and nerve system
❑ Correction of the cause of the problem as well as relief of symptoms ❑ Other _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.

Name of Parent or Guardian _____

Parent or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Thank you for choosing River City Chiropractic. We look forward to helping you!

Patient Name: _____