Gard Wellness Center

Pediatric Intake Form for ages 0-12 years old

Patient Information:

Date: _____

Child's Name: _____ DOB: _____

Parent / Guardian's Name: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____

E-mail Address: _____

Has your child been checked by a Doctor of Chiropractic? Yes No

If yes, please provide the name of the office & doctor. _____

Were x-rays taken Yes No

Who is your medical pediatrician? _____

Prenatal History:

Is your child adopted? Yes No

Did you have any complications and when? _____

Did you smoke? Yes No

Did you consume alcohol? Yes No

Did you take medication? Yes No

Reason for the medication? _____

Birth History:

Did you have ultrasound during this pregnancy? Yes No

What was the frequency? _____

Place of Birth: Home Birthing Center Hospital

Provider: Midwife OB-Gyn Other

Type of Birth: Vaginal C-section

Were pain medications used? Yes No

Was labor induced? Yes No

If yes, why? _____

What position did you deliver in? Squatting On back Other

Birth Trauma? Doctor assisted Twisting and/or Pulling Vacuum Extraction Forceps

Newborn trauma (medical procedures and tests):

APGAR score: birth ____/10 5-minutes ____/10 Unsure

Did your child have a misshaped skull / head? Yes No

Were there purple markings on their face? Yes No

Did you breast feed your child? Yes No

Does your child prefer one breast over the other? Yes No

If yes, which side Right Left

Does your child have any food allergies? Yes No

If yes, please list: _____

Has your child been immunized? Yes No

Reason for vaccination? Informed decision Recommended Didn't know I had a choice.

Did your child have any negative reaction to the vaccinations? Yes No

Were they reported? Yes No

Has your child ever had any surgeries? Yes No

If yes, please elaborate. _____

Has your child been on antibiotics? Yes No

If yes, how often and what for? _____

Is your child currently taking any medication? Yes No

Is you child currently taking any vitamins? Yes No

Baby / Toddler (0-4):

Have any of the following occurred?

Fall from a changing table	Frequent crying spells	Tumble down stairs	Involvement in MVA
Fall out of crib	Fall off of playground equipment	Play in a Johnny Jumper	Frequent ear infections
Tonsillitis	Reaction to vaccines	Frequent fevers	Frequent diarrhea
Constipation	Sleeping problems	Repeated infections or colds	Colic
(+ or -) weight gain	Other (Please explain): _____		

Child (5-12):

Have any of the following occurred?

Fall from a tree	Fall off of a bicycle	Sports accident	Car accident
Stomach pains	Scoliosis	Bed wetting	Fall on playground
Hyperactivity / Autism	Learning difficulties	Asthma	Allergies
Leg / Knee pains	Other (Please explain): _____		

Which of the above bothers your child the most? _____

When did it begin? _____

Is it getting worse?		Yes	No
Is the pain:	Constant	Intermit	Cyclic
Affect on activity?	Not at all	Somewhat	Always

Does your child participate in any of the following?

Soccer	Football	Gymnastics	Karate
Hockey	Lacrosse	Basketball	Dance
Wrestling	Baseball / Softball	Volleyball	Tennis
Swimming	Rugby	Other _____	

How would you rate your child's diet?	Well balanced	Average	High sugar / processed foods
Does your child consume artificial sweeteners?		Yes	No
Fluoridated water?		Yes	No
Number of hours your child sleeps?		_____hours per day	
Sleep Quality?	Good	Fair	Poor

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Authorization to treat a Minor

I, _____the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize the chiropractic physicians at Gard Wellness Center and whomever they may designate as assistant to perform in judgment any examination and chiropractic diagnosis and treatment which is deemed necessary.

Any specific written authorization you may provide may be revoked at any time by writing to us at the address listed on our website, www.gardwellness.com

Signature _____ Date _____