

WELCOME TO IMAGINE WELLNESS CHIROPRACTIC CENTER

822 E. Union Hills Drive Suite 22
Phoenix, AZ 85024
623-582-8951

Pediatric Intake Form

PERSONAL INFORMATION

Child's Full Name: _____ Date: _____

Preferred Name: _____ Date of Birth: _____ Phone: _____

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

Parents Names: _____

Pediatrician: _____ Phone: _____

Siblings Names: _____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____
_____	Age: _____	Sex: _____

Who can we thank for referring you to our office?

Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out the form on their own.

What is/ are the health condition(s) you are concerned with today?

*Major Concerns: _____

When did this condition begin? _____

Is this condition (please circle): Getting Worse Constant Comes & Goes

Is this condition interfering with (please circle): School Sleep Daily Routine

Has the child had this or any similar conditions in the past? _____

Has the child been treated by a Medical Doctor for this condition? _____

If so, where? _____

Results? _____

Has the child ever had Chiropractic Care before? _____

If yes, with whom? _____ Date of last visit? _____

WELLNESS PROFILE- Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Check as many goals as you wish.

- | | | |
|--|---|---|
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Better Sleep | <input type="checkbox"/> Freedom from Pain |
| <input type="checkbox"/> Easier Breathing | <input type="checkbox"/> Improve Nutrition | <input type="checkbox"/> Better Concentration/Focus |
| <input type="checkbox"/> Reduce Medications | <input type="checkbox"/> Try Quality Vitamins | <input type="checkbox"/> Improved Coordination |
| <input type="checkbox"/> More Balanced Posture | <input type="checkbox"/> Improve Overall Health | <input type="checkbox"/> Better Sports Performance |
| <input type="checkbox"/> Enhanced Emotional Well Being | | |
| <input type="checkbox"/> Greater Resistance to Disease, Colds & Infections | | |

HEALTH HISTORY

Please explain any difficulties during pregnancy or labor: _____

The following occurred at delivery (please circle all that apply):

- | | | | |
|------------------|---------------------|---------------------|-------------------|
| Anesthesia Used | Breech Presentation | Emergency C-Section | Face Presentation |
| Forceps/Vacuum | Induced Labor | Intensive Care | Planned C-Section |
| Vaginal Delivery | | | |

Nutrition: my child: Breastfed _____mos Bottle-fed _____mos Started solid foods _____mos

Vaccine: my child has had (please circle):

Standard (Date of last vaccine) _____ Alternative (Date of last) _____ None /Waiver _____

Did they experience side effects or other negative health symptoms? If yes, Please describe symptoms or condition resulting from vaccine _____

PERSONAL HEALTH HISTORY- Has this child ever suffered from (circle all that apply):

- | | | |
|-----------------------|---------------------|-------------------------|
| Major Falls/ Injuries | Fractures | Respiratory Problems |
| Ear Infection | Hyperactivity | Hospitalization |
| Bedwetting | Digestive Problems | Anemia/ Blood Disorders |
| Allergies | Anxiety Disorders | High Blood Pressure |
| Extremity Pain | Back Pain | Orthopedic Problems |
| Speech Problems | Dizziness/ Fainting | Heart Trouble |
| Asthma | Diabetes | Tuberculosis |
| Seizures | Arthritis | Headaches |

Growing Pains

Colic

Sinus Trouble

Neck Pain

Poor Appetite

Behavioral Problems

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s): _____

Allergies to foods or medications: _____

Surgeries: _____

Past serious accidents, falls or injuries: _____

Please answer the following as completely as possible. Does your child:

Take supplements, vitamins or medications? _____

Follow a special diet? _____

Carry a backpack ? _____

Play sports (which ones)? _____

Watch TV (amount per day)? _____

Play computer/video games (amount/day)? _____

FAMILY HEALTH HISTORY- Please circle the conditions below if someone in the child's immediate family has had the following. Please write how they are related to the child.

Scoliosis _____

Headaches _____

High Blood Pressure _____

Ulcer/Digestive Problems _____

Thyroid Disorders _____

Heart Disease _____

Stroke _____

Arthritis _____

Diabetes _____

Cancer _____

Back Pain _____

Mental Illness _____

Consent to Treat a Minor

I hereby authorize Imagine Wellness Chiropractic and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Legal Guardian

Date

Witness

Date