ROCHESTER CHIROPRACTIC & PREGNANCY
PEDIATRIC PATIENT INTAKE

Child's Name: First: _____ MI: ___ Last: _____

DOB: _____ Sex at Birth: M/F Phone: Home/Cell (____) _____

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

Mother's Name: First: _____ Last: _____ Phone: (___) _____

Father's Name: First: _____ Last: _____ Phone: (___) _____

Pediatricians Name: _____ Office Phone: (__) _____
Address: _____ City: _____ State: ___ Zip: _____

Reason for visit: _____ Whom may we thank for your referral? _____

Pregnancy History: (Mother)*:* If the child was adopted, answer to the best of your ability.
Did you experience any of the following during your pregnancy?

__Severe viral infection during first trimester
__ Breech position during pregnancy
__ Accident or Infections
__ Smoking
__ Severe Stress
__ Pre- eclampsia
__ Alcohol and /or Drug use
__ Radiation exposure
__ Hypertension (high blood pressure)
__ Toxoplasmosis
__ Toxemia
__ Gestational Diabetes

Labor/Delivery History: Did you and/or the child experience any of the following during the labor/delivery?

__ Hospital Birth
__ Home Birth
__ Long and/or difficult Labor
__ Forceps or suction cup used
__ Delivery was rapid
__ Labor was induced, with _____
__ Epidural
__ Placenta previa
__ Elective C- Section
__ Emergency C- Section
__ Fetal distress
__ Cord around neck
__ Baby was "Blue Baby"
__ Baby was pre-mature (2+ weeks)
__ Breech birth

Labor Lasted: _____ hours Pushing phase lasted: _____ minutes Gestational age: _____ weeks
Weight at Birth: _____ lbs. oz. _____ Length at Birth: _____ in.

Comments:

_____

_____

_____

Newborn History:

Did the child experience any of the following as a newborn?

__ Required resuscitation/oxygen
__ Prolonged jaundice
__ Poor sleeper
__ Immunizations in hospital
Specify vaccine: _____

__ Distorted skull
__ Difficulty latching/sucking
__ Breast fed
__ Formula fed
__ Bottle fed (breast milk/formula)
__ Colic

Health History:

Has your child ever experienced the following or been diagnosed as having any of the following? or is there a Family History of any of the following?

__ Illness with high fever
__ Frequent headaches
__ Seizures/Convulsions
__ Chronic ear infections/earaches
__ Head injury
__ Serious fall(s) or repetitive falls
__ Serious Illness
__ Epilepsy
__ Meningitis
__ Allergies to foods
__ Environemental allergies
__ Chemical sensitivities
__ Undergone any surgeries
__ Neck or back problems
__ Adverse reactions to vaccines (even if mild)
Explain _____

__ Dizziness
__ Diabetes/ (juvenile)
__ Hypoglycemia (low blood sugar)
__ Trouble with bladder control (enuresis)
__ Fainting
__ High blood pressure
__ Heart disease
__ Asthma
__ Sinus problems
__ Diarrhea
__ Constipation
__ Digestive disorders
__ Rheumatic fever
__ Joint or muscle issues

Developmental History:

Does or did your child have difficulty with any of the following:

__ Crawling (on all fours) or did not crawl
__ Learning to ride bike
__ Learning to read
__ Learning to write
__ Tying shoes
__ Buttoning clothing
__ Using utensils

__ Poor hand-eye coordination
__ Appears clumsy
__ Awkward with walking/running
__ Sitting Still
__ Paying attention
__ Speech issues

At what age did your child start to walk unassisted? _____

Comments:

_____

_____

Neurological/Other: Has your child ever been diagnosed by a medical professional with any of the following:

If yes, by Whom: _____

__ Hearing loss or impairment
__ Neurological disorders
__ ADD/ADHD (attention deficit/hyperactive disorder)
__ OCD (obsessive compulsive disorder)
__ Dyslexia
__ Visual impairment
__ Anxiety/Depression
__ Autism/ Autism Spectrum disorder
__ Tourette Syndrome
__ Other: _____

Current/Past Medications and Treatment (if any)

List any medications that your child is taking:
List names, dosage, frequency
_____
_____

List any special dietary needs that your child has:
_____
_____
_____

List any supplements that your child takes:
_____
_____
_____

List any treatment that your child is currently undergoing with any health professional:
_____
_____

List any special services that your child is currently receiving at school or privately:
_____
_____
_____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:
_____
_____

Comments: _____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize **Dr. Nicole Clemente, D.C.** to evaluate and treat my son/daughter as they deem necessary.

I also acknowledge that I am financially responsible for all fees charged by this office and that payment will be made as services are provided.

_____ _____
Signature and relation of person completing this form Date

_____ _____
Signature of witness Date