Dr. Erica Smothers, DC
2205 Blairsferry Crossing Suite B
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319.826.6879
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PEDIATRIC PATIENT INTAKE FORM

Patient Information

Child's Name________________________________ Parent(s)/Guardians(s) Names__________________________________

Address____________________________________ City__________________________ State________ Zip____________

Home Phone________________________ Cell Phone__________________________ Work Phone________________________

Parent's Email____

Can we leave a voicemail □ No □ Yes Would you like to receive emails (special offers, upcoming events, newsletter) □ No □ Yes

How did you hear about us? ____

Child's Birth Date__________________________ Child's Age____________ Child's Gender_________

Child's Height_____________________________ Child's Weight______________________________

Other Health Care Professionals

Has your child previously been under chiropractic care? □ No □ Yes

If yes, please tell us the doctor's name____

Who is your family's primary care physician? ____

Date and reason for last visit____

Is your child under the care of any other health care professionals? □ No □ Yes

If yes, please list the provider's name, specialty, and date of last visit ________________________________

____

Your Child's Current Health

My child's overall health is: □ Excellent □ Good □ Fair □ Poor

Reason you are seeking care for your child in our office ____

Many children begin chiropractic care as a form of "wellness" or "preventative" care and to increase their body's ability to function and heal. If this is the case for your child, skip to the next section of questions, "Prenatal Period and Birth Experience". Continue with this section if seeking care for your child for a specific condition.

When did this condition begin? ____

What symptoms is your child experiencing? ____

Since the onset, symptoms seem to be: □ Getting better □ Getting worse □ Staying the same

This condition began: □ Suddenly □ Gradually

Has your child had this condition in the past? □ No □ Yes

If yes, please explain____

Is your child under care with another healthcare provider for this condition? □ No □ Yes

If yes, who is the provider? ____

What treatment did they use? ____

What were the results? ____

Prenatal Period and Birth Experience

Complications during pregnancy? □ No □ Yes (describe) ____

Medications during pregnancy? □ No □ Yes (describe) ____

Exposure to drugs/alcohol/tobacco during pregnancy? □ No □ Yes (describe) ________________________________

My child's birth was: □ At home □ At a birthing center □ At a hospital □ Other (describe) _______________________

Attending the birth was my: □ Midwife □ OB □ Doula □ Family physician □ Other

Please list their names____

My child's birth was: □ Natural vaginal delivery (no medications or interventions used)
□ Vaginal delivery with interventions
□ Induction □ Epidural □ Pain medications □ Forceps □ Vacuum extraction
□ Other (please describe) ______________________
□ Premature delivery (If checked, how many weeks gestation?) ______________________
□ C-Section delivery
□ Emergency □ Scheduled

Please list reasons for interventions______________________
Approximately how long were you in labor? ______________________
Is there anything else that you feel we should know about your child's birth process? ______________________
____
Birth Weight______________________ Birth Length______________________
APGAR Score at birth______________________ APGAR Score after 5 minutes______________________

Growth and Development

Is/Was your child breastfed? □ No □ Yes
If yes, how long? ______________________
Any difficulty with breastfeeding? □ No □ Yes (please describe) ______________________
What age was formula introduced? ___________ Type of formula______________________
Any allergies or reactions to formula? ______________________
Introduced cow's milk at age______________________
Introduced solid food at age______________________
Any allergies/intolerances/sensitivities to foods or liquids? □ No □ Yes (please describe) ______________________
____
At what age did your child:
Respond to sound_____________ Hold head up_____________ Sit alone_____________
Crawl_____________ Walk_____________ Teethe_____________
Is your child vaccinated? □ No □ Yes, delayed schedule □ Yes, on schedule
Reaction(s) to vaccinations: □ None □ Fever □ Rash □ Pain at injection site □ Diarrhea □ Vomiting
□ Fatigue □ Excessive crying □ Seizures □ Developmental regression
□ Other (please describe) ______________________
Has your child taken any antibiotics? □ No □ Yes
If yes, how many times and list reason______________________
____
Please list current medications/supplements your child is taking and reason for taking______________________
____
____

Does your child eat dairy products? □ No □ Yes
Does your child eat gluten? □ No □ Yes
Does your child drink caffeinated beverages? □ No □ Yes (If yes, how much per day? ______________________)
Does your child drink water? □ No □ Yes (If yes, how much per day? ______________________)
Has your child ever been hospitalized? □ No □ Yes
If yes, please list reason and year______________________
____
Please list all surgeries, including year______________________
____
Has your child been in a motor vehicle accident? □ No □ Yes (please describe) ______________________
____
Has your child broken any bones? □ No □ Yes (please describe) ______________________
____
Has your child had any major falls or other accidents? □ No □ Yes (please describe) ______________________
____

Does your child play contact sports? □ No □ Yes, seasonally □ Yes, year round
Does your child exercise? □ No □ Rarely □ Weekly □ Daily (What type of exercise? ________________________________)
Does your child watch TV? □ No □ Rarely □ Weekly □ Daily (How many hours? ____________________________________)
Do you think your child is developing normally for their age: Physically □ No □ Yes
Emotionally □ No □ Yes
Intellectually □ No □ Yes

Chiropractic Care

Has anyone you know been under chiropractic care? □ No □ Yes
Did you know that Doctors of Chiropractic work with the nervous system? □ No □ Yes
Did you know that chiropractic is the most utilized natural, drug-free healthcare profession in the world? □ No □ Yes
Do you know what a **subluxation** is? □ No □ Yes
What is your goal for your child under care in our office? ____
____

Do you have any other concerns for your child you would like to address with us (health-related or not)? ___________________
____
____

Consent to Evaluation of a Minor Patient

I, ___________________________________ , hereby grant consent for my child _______________________________ to
(Name of Parent or Legal Guardian) (Print Name of Minor)
receive a chiropractic examination which may include discussing health history, spinal scan, physical examination, and orthopedic and neurological testing by Dr. Erica Smothers, DC at Awaken Family Chiropractic. I understand that all examination findings will be communicated with me, prior to the commencement of care. I have provided accurate information regarding the health of my child, both past and present. The Doctor or staff at Awaken Family Chiropractic will not be held responsible for any omissions or errors made in the completion of this paperwork.

____ ________________________________
Signature of Parent or Legal Guardian Date

AWAKEN FAMILY CHIROPRACTIC

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REVIEW OF SYSTEMS

EYES/EARS/NOSE/THROAT ☐ None

Past	Present	
☐	☐	Glaucoma
☐	☐	Double vision
☐	☐	Blurred vision
☐	☐	Ear infections
☐	☐	Sinus congestion
☐	☐	Sinus infections
☐	☐	Nosebleeds
☐	☐	Toothache
☐	☐	Dizziness
☐	☐	Tinnitus (ringing in ears)
☐	☐	Tonsillitis
☐	☐	Hearing loss
☐	☐	Frequent colds

RESPIRATORY ☐ None

Past	Present	
☐	☐	Asthma
☐	☐	Seasonal allergies
☐	☐	Chronic allergies
☐	☐	Respiratory tract infections
☐	☐	Shortness of breath
☐	☐	Pneumonia
☐	☐	Coughing/wheezing
☐	☐	RSV

GASTROINTESTINAL ☐ None

Past	Present	
☐	☐	Food sensitivities/allergies
☐	☐	Acid reflux
☐	☐	Difficulty swallowing
☐	☐	Constipation
☐	☐	Excessive gas
☐	☐	Diarrhea
☐	☐	Nausea/vomiting
☐	☐	Ulcers
☐	☐	Poor appetite
☐	☐	Colic
☐	☐	Crohn's Disease
☐	☐	Digestive problems

GENITOURINARY ☐ None

Past	Present	
☐	☐	Frequent urination
☐	☐	Burning urination
☐	☐	Bedwetting (enuresis)
☐	☐	Kidney stone
☐	☐	Kidney disease
☐	☐	Prostate problems

MUSCULOSKELETAL ☐ None

Past	Present	
☐	☐	Torticollis
☐	☐	Neck pain
☐	☐	Back pain
☐	☐	Growing pains
☐	☐	Scoliosis
☐	☐	Poor posture
☐	☐	Arthritis
☐	☐	Joint stiffness
☐	☐	Muscle weakness
☐	☐	Osteoporosis
☐	☐	Developmental Dysplasia of the Hip

IMMUNE/SKIN ☐ None

Past	Present	
☐	☐	Autoimmune disorder
☐	☐	Eczema
☐	☐	Rashes
☐	☐	Cortisone use
☐	☐	Weak immune system
☐	☐	Recurrent fevers

CARDIOVASCULAR/LYMPHATIC ☐ None

Past	Present	
☐	☐	Poor circulation
☐	☐	Swollen glands
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Irregular heartbeat
☐	☐	Heart attack
☐	☐	Pacemaker
☐	☐	Leg cramping
☐	☐	High cholesterol
☐	☐	Aneurysm
☐	☐	HIV/AIDS
☐	☐	Stroke
☐	☐	Abnormal bruising

ENDOCRINE ☐ None

Past	Present	
☐	☐	Thyroid problems
☐	☐	Type 1 diabetes
☐	☐	Type 2 diabetes
☐	☐	Hair loss
☐	☐	Menstrual problems
☐	☐	Endometriosis
☐	☐	Fertility issues

NEUROLOGICAL ☐ None

Past	Present	
☐	☐	Asymmetric crawl/gait
☐	☐	Sleep disturbances
☐	☐	Seizures
☐	☐	Tics/tremors/shaking
☐	☐	Autism/Spectrum disorder
☐	☐	ADD/ADHD
☐	☐	Sensory processing disorder
☐	☐	Toe walking
☐	☐	Headaches/migraines
☐	☐	Numbness/tingling
☐	☐	Parkinson's disease
☐	☐	Sciatica
☐	☐	Carpal tunnel syndrome
☐	☐	Balance/coordination issues
☐	☐	Trigeminal neuralgia
☐	☐	Fine motor problems
☐	☐	Gross motor problems

PSYCHIATRIC ☐ None

Past	Present	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	OCD
☐	☐	Bipolar disorder
☐	☐	Difficulty sleeping
☐	☐	Seasonal affective disorder
☐	☐	Memory loss
☐	☐	Mood swings

GENERAL ☐ None

Past	Present	
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Low energy
☐	☐	Learning disabilities
☐	☐	Behavior issues
☐	☐	Speech delays
☐	☐	Chronic fatigue
☐	☐	Obesity
☐	☐	Fibromyalgia
☐	☐	Cancer

Any immediate family members diagnosed with the following:

☐ Cancer________________________________

☐ Heart Disease ___________________________

☐ Stroke ________________________________

☐ Aneurysm ______________________________

☐ Diabetes _______________________________

☐ Seizures _______________________________

☐ Liver disease ____________________________

☐ High blood pressure ______________________

☐ High cholesterol _________________________

☐ Depression _____________________________

☐ Other major medical condition ____________

____