Pediatric Intake

Appointment Date____________

2205 Blairsferry Crossing B
Hiawatha, Iowa 52233
319.826.6879
awakenfamilychiro@gmail.com

Patient Information

Child's Name________________________________ Parent/Guardian(s) Name__________________________
Street Address ____
City, State, Zip ____
Cell Phone ___________________ Other Phone __________________ Can we leave a voicemail? ☐ Yes ☐ No
Email ____
Would you like to receive emails (special offers, upcoming events)? ☐ Yes ☐ No
How did you hear about our office? ____
Birthdate ________________ Age _________ Child's Gender_________ Weight _________ Height_________
Who is your child's primary care physician? ____
Date and reason for last visit ____

Your Child's Current Health

My child's overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Reason for seeking care at our office ____
If applicable, 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
Has your child received any other treatment for this condition? ______________________________________
How is this condition affecting daily activities? ____
____

Prenatal Period and Birth Experience

Any complications during pregnancy? ☐ No ☐ Yes (describe) ______________________________________
Medications during pregnancy? ☐ No ☐ Yes (describe) ____
Notable mental/physical stress during pregnancy? ☐ No ☐ Yes (describe) __________________________
____
My child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ Other__________________
Attending the birth was my: ☐ Midwife ☐ OB ☐ Doula ☐ Family physician ☐ Other _______________
My child's birth was: ☐ Natural vaginal delivery (no medications or interventions)
☐ Vaginal delivery with interventions:
☐ Induction ☐ Epidural ☐ Pain meds ☐ Forceps ☐ Vacuum extraction
☐ Premature delivery (If checked, how many weeks gestation? __________________)
☐ C-section delivery
☐ Emergency ☐ Scheduled
How long was active labor? _____________________________ How long did you push? ________________
Birth Weight _______________________ Birth Length _________________________
Is there anything else we should know about your pregnancy or labor/delivery? _________________________
____
____

Your Child's Health Habits

Is/ was your child breastfed? ☐ No ☐ Yes (If yes, how long? ________________________)

Any difficulties breastfeeding? ____

What age did you introduce: Formula ______________ Solids ________________ Cow's milk _____________

Any dietary restrictions, allergies, sensitivities, etc? ______________________________________

____

Is your child vaccinated? ☐ No ☐ Yes, delayed schedule ☐ Yes, on schedule

Any reaction(s) to vaccinations: ☐ None ☐ Fever ☐ Rash ☐ Pain at injection site ☐ Diarrhea ☐ Fatigue ☐ Vomiting ☐ Excessive crying ☐ Seizures ☐ Developmental regression ☐ Other (describe) ______________________________________

How much does your child exercise? ☐ None ☐ Rarely ☐ Weekly ☐ Daily

What type of exercise? ____

Average hours of sleep per night? ___________ How much water does your child drink per day? __________

How many hours per day does your child spend on a computer/tablet/phone? ___________________

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please like reason and year ____

____

Please list all surgeries, including year ____

____

Has your child been in a motor vehicle accident? ☐ Yes ☐ No

If yes, please describe ____

Has your child broken any bones? ☐ Yes ☐ No

If yes, please describe ____

Has your child had any major falls, injuries, or other accidents? ☐ Yes ☐ No

If yes, please describe ____

____

Has your child had any significant illnesses (including COVID-19)? ___________________________

____

Has your child received a COVID-19 vaccine? ☐ Yes ☐ No Booster dose(s)? ☐ Yes ☐ No

Please list current medications/supplements your child is taking and reasons for taking them _____________

____

Please list any significant family medical history (immediate family members) ____________________

____

____

Do think your child is developing normally for their age:

Physically	☐ Yes	☐ No
Emotionally	☐ Yes	☐ No
Intellectually	☐ Yes	☐ No

Chiropractic Care

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

If yes, please list office name and date of last visit? _________________________________

Did you know that Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

Did you know that chiropractic care is the most utilized natural, drug-free healthcare profession? ☐ Yes ☐ No

What is your health goal for your child while under care at our office? ___________________________

____

Do you have any other concerns you would like to address with us (health-related or not)? ______________

____

Patient Review of Systems

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EYES/EARS/NOSE/THROAT ☐ None

Past	Present	
☐	☐	Blurred or double vision
☐	☐	Vertigo & dizziness
☐	☐	Ear & sinus infections
☐	☐	Sore throat
☐	☐	Nosebleeds
☐	☐	Swollen tonsils & adenoids
☐	☐	Hearing loss
☐	☐	Tinnitus (ringing in ears)
☐	☐	Speech issues
☐	☐	TMJ/jaw pain

RESPIRATORY ☐ None

Past	Present	
☐	☐	Asthma
☐	☐	Seasonal allergies
☐	☐	Chronic colds or cough
☐	☐	Pneumonia
☐	☐	Shortness of breath
☐	☐	RSV

GASTROINTESTINAL ☐ None

Past	Present	
☐	☐	Food sensitivities/allergies
☐	☐	Reflux/GERD
☐	☐	Stomach pains
☐	☐	Nausea/vomiting
☐	☐	Ulcers
☐	☐	Jaundice
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive gas or bloating
☐	☐	Chron's, colitis, IBS
☐	☐	Gallbladder pain/issues
☐	☐	Poor appetite
☐	☐	Hemorrhoids
☐	☐	Gluten/casein intolerance

CARDIOVASCULAR ☐ None

Past	Present	
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Anemia
☐	☐	Stroke
☐	☐	Heart condition
☐	☐	Leg cramping/swelling
☐	☐	Aneurysm
☐	☐	Poor circulation

ENDOCRINE ☐ None

Past	Present	
☐	☐	Infertility
☐	☐	Cysts or endometriosis
☐	☐	Menstrual issues
☐	☐	Hair loss
☐	☐	Diabetes Type I or II
☐	☐	Thyroid issues
☐	☐	Weight gain
☐	☐	Weight loss
☐	☐	Chronic fatigue
☐	☐	Impotency

NEUROLOGICAL ☐ None

Past	Present	
☐	☐	Headaches or migraines
☐	☐	Sleep disturbances
☐	☐	Walking challenges
☐	☐	Numbness/tingling
☐	☐	Sciatica
☐	☐	Carpal tunnel syndrome
☐	☐	Seizures
☐	☐	Sensory/spectrum disorder
☐	☐	ADD/ADHD
☐	☐	Focus or memory issues
☐	☐	Tics/tremors/shaking
☐	☐	Toe walking
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Behavior issues
☐	☐	Colic or excessive crying
☐	☐	Balance/coordination issues

IUMMUNE/SKIN ☐ None

Past	Present	
☐	☐	Eczema
☐	☐	Rashes or skin issues
☐	☐	Recurrent fevers
☐	☐	Immune deficiency
☐	☐	Autoimmune disorder
☐	☐	Swollen glands
☐	☐	Cancer

GENITOURINARY ☐ None

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

MUSCULOSKELETAL ☐ None

Past	Present	
☐	☐	Neck pain
☐	☐	Low back pain
☐	☐	Scoliosis
☐	☐	Arthritis
☐	☐	Poor posture
☐	☐	Disc degeneration
☐	☐	Muscle weakness
☐	☐	Osteoporosis
☐	☐	Shoulder/arm/hand pain
☐	☐	Knee/ankle/foot pain
☐	☐	Weak ankles or arches
☐	☐	Hip dysplasia
☐	☐	Torticollis

Consent for Chiropractic Examination

I hereby grant consent for myself and/or my child to receive a chiropractic examination which may include discussing health history, spinal scans, physical examination and other neurologic or orthopedic testing by Dr. Erica Smothers at Awaken Family Chiropractic. I understand that findings will be communicated with me prior to commencement of care. By signing, I agree that I have provided accurate health information, both past and present. Awaken Family Chiropractic will not be held responsible for any omissions or errors made in the completion of this paperwork.

______________________________________ ________________________
Signature of Patient or Legal Guardian Date