PEDIATRIC INTAKE PACKET

Patient Demographics Today's Date: _____

Name:_____ Date of Birth:_____-_____-_____ Age:_____ Male / Female

Birth Height:_____ Birth Weight:_____ Current Height:_____ Current Weight:_____

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

Mothers Name:_____ Mothers Cell Number: _____

Fathers Name: _____ Fathers Cell Number: _____

Name of Pediatrician/Family MD: _____ City & State:_____

Last Visit: _____/_____/_____ Reason for Visit:_____

Child's Current Problem

Purpose of this visit: □ Wellness Check-up □ Injury or Accident □ Other: _____

If your child is experiencing Pain/Discomfort please identify where and for how long:_____

_____

_____

1. When did the problem first begin? Date: _____/_____/_____ _____ Suddenly _____ Gradually _____ Unknown
2. Has your child ever had this problem before? □ Yes □ No If yes, when? _____
3. Any bowel or bladder problems since this problem began? □ Yes □ No If yes please describe below:

   _____
4. Have you seen any other doctors for this problem? □ Yes □ No
   a. If yes, who? _____
   b. How long ago did you see them? _____ Days _____ Weeks _____ Months _____ Years
   c. What were the results of the past treatment? _____
5. How is the problem **NOW**: □ Rapidly Improving □ Improving Slowly □ About the Same
   □ Gradually Worsening □ On & Off
6. Please list any medication taken for this problem: _____
7. Has your child ever sustained an injury playing organized sports? □ Yes □ No If yes; please explain below

_____

_____

8. Has your child ever sustained an injury in an auto accident? □ Yes □ No If yes; please explain below

_____

_____

9. Does your child have any allergies? □ Yes □ No If yes; what? _____

Has your child ever suffered from (please mark Y for YES and N for NO

___ Headaches	___ Orthopedic Problems	___ Digestive Disorders	___ Behavioral Problems
___ Dizziness	___ Neck Problems	___ Poor Appetite	___ ADD/ADHD
___ Fainting	___ Arm Problems	___ Stomach Aches	___ Raptures/Hernia
___ Seizures/Convulsions	___ Leg Problems	___ Reflux	___ Muscle Pain
___ Chronic Earaches	___ Backaches	___ Diarrhea	___ Sinus Trouble
___ Poor Posture	___ Hypertension	___ Asthma	___ Scoliosis
___ Anemia	___ Cold/Flu	___ Walking Trouble	___ Bed Wetting
___ Colic	___ Broken Bones	___ Sleeping Problems	___ Fall in Baby Walker
___ Fall from Bed or Couch	___ Fall from Crib	___ Fall off Swing	___ Fall off Bicycle
___ Fall from High Chair	___ Fall off Slide	___ Fall Down Stairs	___ Fall from Changing Table
___ Fall off Monkey Bars	___ Fall off Skateboard/Skates	___ Other: _____	

I understand that I am directly and fully responsible to Dr. Neill Heim or Dr. Leigh Sierra for all fees associated with the chiropractic care my child receives.

The risks associated with ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After Careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

□ Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

Doctor Signature _____ Date _____