Bird Concierge Chiropractic

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Pediatric Intake Below 5 years of age

Last Name First Name MI	Date	Date of Birth

I. HISTORY (obtained from _____)

A. Mother's health during pregnancy

B. Labor and delivery ❒ c-section ❒ vacuum assisted ❒ forceps ❒ other trauma (describe)

C. Neonatal health of infant *# of weeks delivered* _____

D. Growth and development *growth percentile* _____%

E. Diet and feeding ❒ Breastfed ❒ Bottle- breastmilk ❒ Bottle - formula How long?

F. Vaccines ❒ vaccinated ❒ not vaccinatied ❒ modified schedule

G. Previous diseases, injuries (include date)

H. Operations, Hospitalizations (include date)

I. Mental development

J. Emotional adjustments

K. Family history

_____ _____

Doctor's Signature Date

Last Name	First Name	MI	Date	Date of Birth

II. Chief Complaint: _____

_____

_____

1. When, or approximately when, did the chief complaint start?	Date / Time:_____
2. Did it begin gradually or suddenly?	
3. Describel the exact location of the pain / problem.	
4. Did anyting cause or contribute to the onset?	❒ Yes ❒ No
5. How would you rate the intensity of your child's complaint? (mild, moderate, severe)	
6. Has your child had anything like this before?	❒ Yes ❒ No
7. Has the condition been constant or intermittent? (circle one)	
8. Is the condition getting worst or better? (circle one)	
9. What makes it better? (rest, time of day, positions, other)	
10. What makes it worse?	
11. Has there been any change in your child.s bodily functions? (urination, defecation, respiration, digestion, vision, hearing, other)	❒ Yes ❒ No
12. Has the condition affected your child's activities?	❒ Yes ❒ No
13. Have you tried any home remedies? If yes, what?	❒ Yes ❒ No
14. Has the condition affected your child's activities?	❒ Yes ❒ No
15. List any medications, prescription /non- prescription.	
16. Are there any other symptoms or problems you wish to talk about?	❒ Yes ❒ No

_____ _____

Doctor's Signature Date