Optimal Vitality Chiropractic
Brain - Body - Balance

CHILD INTAKE FORM

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Name:_____ Age:_____ Date of Birth:_____

Child's Sex: O Male O Female Purpose of Appointment:_____

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

Parent Phone # (H):_____ (W):_____ (C):_____

Parent Email:_____

Medical Doctors Name:_____ Referred By:_____

Have you ever received Chiropractic Care? (Circle One) Yes No

If yes, by who?_____ When?_____ For how long?_____ X-Ray's?_____

If Child Was Adopted

Child's age when adopted?_____ Known Health History of Child:_____

Pregnancy Information

Pregnancy History:_____

Pre-natal Supplements? O Yes O No Omega 3 Supplement? O Yes O No Pro-biotic Supplement? O Yes O No

Organic Diet? O Yes O No Any Prolonged Emotional Stress During Pregnancy? O Yes O No

Medications Taken During Pregnancy?_____

Any Problems During Pregnancy and/or Delivery? O Yes O No If yes, please explain:_____

_____

Birth Information

Birth Weight:_____ Birth Length:_____ Epidural: O Yes O No

Type of Birth: O Vaginal O Forceps O Breech O Cesarean O Home O Birthing Center O Hospital

Apgar Scores:_____ Jaundice (Yellow) at Birth?_____ Cyanosis (Blue)?_____

Congenital Anomalies/Defects?_____

Infant Feeding: O Breast O Bottle Formula:_____ Any Issues With Feeding?_____

Other Food and Drink Information:_____

Number of Hours Child Sleeps Daily:_____ Quality of Sleep: O Good O Fair O Poor

Comments:_____

Number of Siblings:_____ Siblings Names, Ages and Sex:_____

_____

Date of Last Visit To Any Doctor:_____ Reason For That Visit:_____

Was Child Immunized? O Yes O No Immunization History:_____

Has child ever been treated on an emergency basis? O Yes O No

If yes, please explain:_____

Has child ever had any type of surgery? O Yes O No If yes, please explain:_____

Development History – At what age did the child:

Respond to sound:_____ Crawl:_____ Follow an object with eyes:_____

Hold head up:_____ Stand:_____ Sit alone:_____ Walk Alone:_____

Symptoms/State of Ill Health

Please note **ANY** of the following signals that the child has presented, even if you feel they are unrelated:

O Headaches	O Diabetes	O Buzzing in Ears	O Fainting
O Neck Pain	O Neck Problems	O Fever	O Loss of Smell
O Sleeping Problems	O Arm Problems	O Neck Stiffness	O Loss of Taste
O Bed Wetting	O Numbness in Toes &/or Fingers	O Ringing in the Ears	O Diarrhea
O Nervousness	O Shortness of Breath	O Loss of Balance	O Cold Feet
O Tension	O Fatigue	O Backaches	O Cold Hands
O Irritability	O Depression	O Face Flushed	O Stomach Aches
O Chest Pains	O Sensitivity to Light	O Cold Sweats	O Constipation
O Dizziness	O Dyslexia	O Mood Swings	O Bladder Problems
O Sinus Problems	O Ear Infections	O Blood Pressure Problems	O ADHD or ADD
O Heart Trouble	O Orthopedic Problems	O Sugar Concentration	O Leg Problems
O Behavioral Problems	O Poor Appetite	O Joint Problems	O Convulsions
O Walking Problems	O Digestive Disorders	O Arthritis	O Muscle Jerking
O Rheumatic Fever	O Blood Disorder	O Hyperactivity	O Neuritis
O Ruptures/Hernias	O Allergies	O Hypertension	O Broken Bones
O Anemia	O Tuberculosis	O "Growing Pains"	O Asthma
O Paralysis	O Anemia	O Cold/Flu	O Chronic Earaches

Is child under drug and medical care?_____

Any medications or supplements the child is taking?_____

How long has he/she been taking them?_____ Any side-effects experienced from the drugs?_____

Is there a family history of:	High BP	Heart Disease	Arthritis	Cancer	Diabetes	Stroke	Other_____
Father's Side:	O	O	O	O	O	O	O
Mother's Side:	O	O	O	O	O	O	O

On a scale of 1-10, rate the importance of you wanting your child to achieve the following:

	1 = Not Important								**10 = Necessary**	
Get Fit	1	2	3	4	5	6	7	8	9	10
Eat Better	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Reduce Pain	1	2	3	4	5	6	7	8	9	10
Increase Mobility	1	2	3	4	5	6	7	8	9	10
Improve Sleep	1	2	3	4	5	6	7	8	9	10
Learn About Wellness and Natural Health Care	1	2	3	4	5	6	7	8	9	10
Improve Immune Function	1	2	3	4	5	6	7	8	9	10
Other (List):_____	1	2	3	4	5	6	7	8	9	10

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

_____ _____ _____

(Signature) (Relationship) (Date)