DR. CARMONA CHIROPRACTIC

Dr. Heather Carmona, D.C.
Pediatric Intake Form (Birth-12 years old)

***Patient Information*:**
Date:_____
Child's Name:_____**DOB:**_____
Parent/Guardian Name: _____**DOB:**_____
Relationship to Patient: _____
Home Phone #:_____**Cell Phone #:**_____
Address:_____
E-mail Address:_____
Has your child been checked by a Doctor of Chiropractic? ☐Yes ☐ No
If yes, please provide the name of the office & doctor._____
Were x-rays taken? ☐Yes ☐ No
Who is your medical pediatrician?_____
Insurance Information:
Subscriber Name:_____**Health Plan:**_____
Subscriber ID#:_____**Group #:**_____**Spouse Name:**_____
Subscriber Date of Birth:_____
Prenatal History:
Is your child adopted? ☐Yes ☐ No
Did you have any complications and when?_____
Did you smoke? ☐Yes ☐ No
Did you consume alcohol? ☐Yes ☐ No
Did you take medication? ☐Yes ☐ No
Reason for the medication? _____
Birth History:
Did you have ultrasound during this pregnancy? ☐Yes ☐ No
What was the frequency? _____
Place of Birth: ☐Home ☐Birthing Center ☐Hospital
Provider: ☐Midwife ☐OB-Gyn ☐Other
Type of Birth: ☐Vaginal ☐C-section
Were pain medications used? ☐Yes ☐ No
Was labor induced? ☐Yes ☐ No
If yes, why? _____
What position did you deliver in? ☐Squatting ☐On Back ☐ Other
Birth Trauma? ☐Doctor assisted ☐Twisting and/or pulling ☐Vacuum Extraction ☐Forceps
Newborn trauma (medical procedures and tests):
APGAR score: birth_____ /10 5-minutes _____/10 ☐Unsure
Did your child have a misshaped skull/head? ☐Yes ☐ No
Were there purple markings on their face? ☐Yes ☐ No
Did you breast feed your child? ☐Yes ☐ No
Does your child prefer one breast over the other? ☐Yes ☐ No
If yes, which side? ☐Right ☐ Left
Does your child have any food allergies? ☐Yes ☐ No
If yes, please list:_____
Has your child been immunized? ☐Yes ☐ No

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Reason for vaccination? ☐Informed decision ☐Recommended ☐Didn't know I had a choice
Did your child have any negative reaction to the vaccinations? ☐Yes ☐ No
Were they reported? ☐Yes ☐ No
Has your child ever had any surgeries? ☐Yes ☐ No
If yes, please elaborate._____
Has your child been on antibiotics? ☐Yes ☐ No
If yes, how often and what for?_____
Is your child currently taking any vitamins? ☐Yes ☐ No

Baby/Toddler (0-4):

Have any of the following occurred?

☐Fall from changing table ☐Frequent crying spells ☐Tumble down stairs ☐Involvement in MVA
☐Fall out of crib ☐Fall off of playground equipment ☐Play in a Johnny Jumper ☐Frequent ear infections
☐Tonsillitis ☐Reaction to vaccines ☐Frequent fevers ☐Frequent diarrhea
☐Constipation ☐Sleeping problems ☐Repeated infections or colds ☐Colic
☐ (+ or -) weight gain ☐Other (Please explain):_____

Child (5-12):

Have any of the following occurred?

☐Fall from tree ☐Fall off of bicycle ☐Sports accident ☐Car accident
☐Stomach pains ☐Scoliosis ☐Bed wetting ☐Fall on playground
☐Hyperactivity/Autism ☐Learning Difficulties ☐Asthma ☐Allergies
☐Leg/Knee pains ☐Other (Please explain):_____
Which of the above bothers your child the most?_____
When did it begin?_____
Is it getting worse?_____
Is the pain: ☐Constant ☐Intermittent ☐Cyclic
Affect on activity? ☐Not at all ☐Somewhat ☐Always

Does your child participate in any of the following?

☐Soccer ☐Football ☐Gymnastics ☐Karate
☐Hockey ☐Lacrosse ☐Basketball ☐Dance
☐Wrestling ☐Baseball/Softball ☐Volleyball ☐Tennis
☐Swimming ☐Rugby ☐Other: _____

How would you rate your child's diet? ☐Well balanced ☐Average ☐High sugar/processed foods
Does your child consume artificial sweeteners? ☐Yes ☐ No
Fluoridated water? ☐Yes ☐ No
Number of hours your child sleeps? _____hours per day
Sleep quality: ☐ Good ☐Fair ☐ Poor

Authorization to treat a Minor

I, _____the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Carmona and whomever she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on this form.

DR. CARMONA CHIROPRACTIC

Patient: _____ **Signature:** _____

Print Name *Parent/Legal guardian*

24-Hour Cancellation/Rescheduled Policies of Appointment

24-hour advance notice is required when cancelling or rescheduling a Chiropractic appointment. If you are unable to give us at least 24 hours advance notice you will be charged $50 for your missed Chiropractic appointment. You will received a courtesy appointment reminder via automated text and/or email, but please know this is a courtesy and should plan accordingly for your appointment. Thank you for your understanding.

“I have read, understand and agree to the provisions of this policy.”

_____	_____
PATIENT NAME	PATIENT SIGNATURE/GUARDIAN