



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



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.***



**Patient:** \_\_\_\_\_  
*Print Name*

**Signature:** \_\_\_\_\_  
*Parent/Legal guardian*