BACK in line
FAMILY CHIROPRACTIC AND WELLNESS
99 North Center Point Road
Hiawatha, IA 5233

Office Use
BP:____/____
Pulse:_____
Weight:_____

Confidential New Patient Intake Form (Pediatric)

Patient Information:

Date:_____ Referred by: _____ (may we thank them for their referral? Y/N)
Patient Name: _____ Parent/Guardian Name(s):_____
Address:_____ City:_____ State:____ Zip Code:_____
Home Phone #:_____ Cell Phone#:_____ Work Phone #:_____
Parent/Guardian(s) email address:_____
Can we Text or Email you to remind you about your appointment? ☐ Email ☐ Text ☐ No Thanks
(We will use the number or email above unless you specify otherwise)
How would you prefer to be contacted by our office (scheduling, questions, concerns)?
☐ Email ☐Cell Phone ☐Home Phone ☐Work Phone ☐ Ok to leave a Voicemail
Date of Birth: ____/_____/_____ Age:_____ Gender: _____
Approximate Height:_____ Approximate weight:_____

Previous Providers:

Has your child been to a chiropractor before?: ☐YES ☐NO
If Yes, who was the physician?_____
Reason for leaving:_____
Is your child currently seeing any other physician or healthcare professional?: ☐YES ☐NO
If Yes, who is the provider?_____
Date of last visit: _____ Reason for care:_____

Current Health and Habits:

I would describe my child's overall health as (circle one): Excellent, Good, Fair, or Poor
Reason you are seeking care for your child at Back In Line: _____
(Many children begin chiropractic as a form of wellness/preventative care, simply to help their child function the best they possibly can. If this is the case, you can skip down to the "Pregnancy and Birth" part of this questionnaire.)
What symptoms are being experienced?:_____
When did the symptoms begin?:_____
Has anything like this occurred before (if yes, when)?_____
Did this condition begin suddenly or gradually?_____
Have you found anything that makes it better or worse? _____
Since it began, are the symptoms improving, worsening, or staying the same?_____
Has your child been seen by another healthcare provider for this condition? ☐YES ☐NO
If Yes, who was the physician?_____
What was the treatment? _____
What were the results? _____

Pregnancy and Birth:

Were there any complications during the pregnancy? (describe): _____
Any medications taken during pregnancy? (describe) _____
Smoking or alcohol use during pregnancy? ☐Yes ☐No
Birth took place at: ☐Hospital ☐Birth Center ☐Home ☐Other _____
Persons attending the birth: ☐Midwife ☐OB ☐Doula ☐Family Physician ☐Other
Names of those checked above: _____
Child's birth was:
☐Natural (vaginal deliver, no medications or interventions used)
☐Vaginal delivery with interventions (circle any of the following below that occurred)
Induction, Epidural, Pain medication, Forceps, Vacuum Extraction
If other, please describe_____
☐Premature deliver (weeks gestation _____)
☐Cesarean Section (☐Emergency ☐Scheduled)
Please list reasoning for interventions _____
Approximately how long were you in labor?_____ Birth weight _____ Birth Length _____
APGAR Score at Birth _____ APGAR Score at 5 minutes _____

Growth and Development:

Has your child been breastfed? ☐Yes, currently ☐Yes, but not anymore ☐No
If yes, how long?_____ Any difficulty breastfeeding? ☐Yes ☐No
Was formula introduced? ☐Yes ☐No When?_____ What kind?_____
Has cow's milk been introduced? ☐Yes ☐No When?_____
Has solid food been introduced? ☐Yes ☐No When?_____
Any known allergies or intolerances to food or drink? ☐No ☐Yes (please describe) _____
_____
Does your child… (check all applicable)
☐Hold head up ☐Stand unassisted ☐Walk
☐Sit unassisted ☐Crawl ☐Teethe

Eating habits and Activity level:

What are you child's favorite foods?_____
Does your child eat:
☐Dairy ☐Gluten/Wheat ☐Sugar ☐Eggs ☐Soy ☐Caffeine
Does your child drink water? ☐Yes ☐No How much?_____
Does your child play outside? ☐Yes ☐No How often?_____
What are your child's favorite activities? _____
Does your child play sports? ☐Yes ☐No Which sports? _____
Does your child watch TV? ☐No ☐Rarely ☐Weekly ☐Daily (total hours_____)
Number of hours sleeping per night: _____ Quality of Sleep: ☐Good ☐Fair ☐Poor
Number of naps per day: _____ Length of naps:_____ Quality of Sleep: ☐Good ☐Fair ☐Poor

Past Health History:

Has your child ever been hospitalized? ☐No ☐Yes (why?) _____
_____
Has your child had surgery? ☐No ☐Yes (why?) _____
_____
Has your child experienced trauma? (motor vehicle accidents, broken bones, falls off beds/changing tables/down stairs, other accidents):

Is your child vaccinated? ☐No ☐Yes, on a delayed or alternate schedule ☐Yes, on schedule
Reactions to vaccinations?
☐None ☐Fever ☐Rash ☐Pain at injection site ☐Diarrhea ☐Vomiting
☐Fatigue ☐Excessive Crying ☐Seizures ☐Developmental delays or regression
☐Other: _____
Has your child ever taken antibiotics? ☐No ☐Yes (explain) _____
Please list any current medications or nutritional supplements your child is taking, and reason for taking: _____
_____

Do you have any other concerns for you would like to address with us? (write below)
We are here to serve you as our patient, and we encourage you to ask questions!
Your participation is VITAL and will help determine your results.

Consent to Evaluate a Minor Patient

I, _____, hereby grant consent for my child _____
(Name of parent or guardian) (Name of child)

To receive a chiropractic examination which may include discussion of health history, physical examination, orthopedic testing and neurological testing, by Dr. Hannah Anderson, DC at Back In Line Family Chiropractic and Wellness. I understand that all examination findings will be communicated with me prior to the commencement of care. I have provided accurate information regarding the health of my child, both past and present. The physicians or staff at Back In Line will not be held responsible for any omissions or errors made in the completion of this paperwork. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____
Signature of Parent/Guardian Date

BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

REVIEW OF SYSTEMS

EENT ☐None

Past	Present	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Double Vision
☐	☐	Blurred Vision
☐	☐	Ear Infections
☐	☐	Sinus Infection
☐	☐	Nosebleeds
☐	☐	Dizziness
☐	☐	Ringing in ears
☐	☐	Tonsilitis
☐	☐	Hearing Loss
☐	☐	Frequent Colds

Respiratory ☐None

Past	Present	
☐	☐	Asthma
☐	☐	Allergies
☐	☐	Respiratory infection
☐	☐	Shortness of breath
☐	☐	Pneumonia
☐	☐	Coughing/Wheezing
☐	☐	RSV

Any other diagnoses not listed: _____

_____

_____

GI ☐None

Past	Present	
☐	☐	Acid Reflux
☐	☐	Difficulty swallowing
☐	☐	Constipation
☐	☐	Excessive Gas
☐	☐	Diarrhea
☐	☐	Nausea/Vomiting
☐	☐	Ulcers
☐	☐	Poor appetite
☐	☐	Crohn's disease
☐	☐	Digestive problems
☐	☐	Liver problems
☐	☐	Gallbladder problems

Other: _____

Genitourinary ☐None

Past	Present	
☐	☐	Frequent urination
☐	☐	Burning urnation
☐	☐	Blood in urine
☐	☐	Bedwetting
☐	☐	Kidney Stone
☐	☐	Kidney Disease
☐	☐	Prostate Problems

Immune System ☐None

Past	Present	
☐	☐	Autoimmune disorder
☐	☐	Eczema
☐	☐	Rashes
☐	☐	Cortisone Use
☐	☐	Recurrent Fevers

Psychiatric ☐None

Past	Present	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	OCD
☐	☐	Bipolar Disorder
☐	☐	Insomnia
☐	☐	Seasonal Affective
☐	☐	Memory Loss
☐	☐	Mood Swings

Musculoskeletal ☐None

Past	Present	
☐	☐	Neck Pain
☐	☐	Back Pain
☐	☐	Growing Pains
☐	☐	Scoliosis
☐	☐	Poor Posture
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Joint Stiffness
☐	☐	Muscle Weakness
☐	☐	Osteoporosis
☐	☐	Joint Replacement
☐	☐	Hip Dysplasia

General ☐None

Past	Present	
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Low energy
☐	☐	Learning disabilities
☐	☐	Behavior issues
☐	☐	Speech delays
☐	☐	Chronic Fatigue
☐	☐	Fibromyalgia
☐	☐	Cancer
☐	☐	Obesity

☐	☐	HIV/AIDS
☐	☐	Stroke
☐	☐	Abnormal Bruising

Endocrine ☐None

Past	Present	
☐	☐	Thyroid problems
☐	☐	Diabetes
☐	☐	Hair loss
☐	☐	Menstrual problems
☐	☐	Endometriosis
☐	☐	Fertility Issues
☐	☐	Hashimotos

Cardiovascular ☐None

Past	Present	
☐	☐	Poor Circulation
☐	☐	Anemia
☐	☐	High Blood Pressure
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Jaw Pain
☐	☐	Irregular heartbeat
☐	☐	Pacemaker
☐	☐	Leg cramps/swelling
☐	☐	High Cholesterol
☐	☐	Aneurysm

Neurological ☐None

Past	Present	
☐	☐	Asymmetric Gait
☐	☐	Sleep disturbances
☐	☐	Seizures
☐	☐	Tics/Tremors/Shakes
☐	☐	Autism
☐	☐	ADD/ADHD
☐	☐	Toe Walking
☐	☐	Headaches/migraines
☐	☐	Numbness/tingling
☐	☐	Radiating Pain
☐	☐	Parkinson's Disease
☐	☐	Sciatica
☐	☐	Carpal Tunnel Syndrome
☐	☐	Coordination issues
☐	☐	Trigeminal Neuralgia
☐	☐	Fine Motor Problems
☐	☐	Gross Motor Problems