2717 N. Grandview Blvd. Suite 101, Waukesha, WI 53188
(262) 349-9370 ● purechiropracticandwellness.com

Pediatric Intake Form

(birth to 5 years old)

DATE ______________

PERSONAL INFORMATION

Child's First Name: ______________________ M.I: ____ Last Name: ______________________

Preferred Name: ______________________

Address: ____

City / State / Zip: ____

Birth Date: _____-_______-_______ Age: ________ Sex: M F

# of Siblings: _____ Sibling's Names & Ages: ______________________

Parent's Names: ____

Cell Phone: ( )______________________ Alternate Phone: ( )______________________

Parent's Email: ______________________

Who can we thank for referring you or how did you hear about our office? :

____

REASON FOR SEEKING CARE

What is your reason for seeking care at Pure Chiropractic and Wellness? ______________________

____

When did this begin? (if applicable) ______________________

Are there any major injuries and/or surgeries we should know about? ______________________

____

What is this affecting that is MOST important in your child's life? (list all that apply)

____

Has your child seen any other providers for this condition? (list all that apply)

____

Has your child seen a chiropractor before? Yes ◯ No ◯

How long ago? __________ Clinic/Doctor Name: ______________________

What is your reason for the change? (if applicable) ______________________

What is your level of commitment to your child's health? 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Explain: ____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life?

____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain/Stiffness
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's
- ☐ Sensory Processing Disorder and Challenges
- ☐ Other ____
- ☐ Other ____
- ☐ Other ____

Explain any boxes checked above:

____

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____

Is there anything else regarding your child's current condition you feel the doctor should know? _____________

____

____

____

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____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Antibiotics
- ☐ Migraine/Headache
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Digestive
- ☐ Other ____
- ☐ Other ____
- ☐ Other ____

Explain any boxes checked above: _____________________

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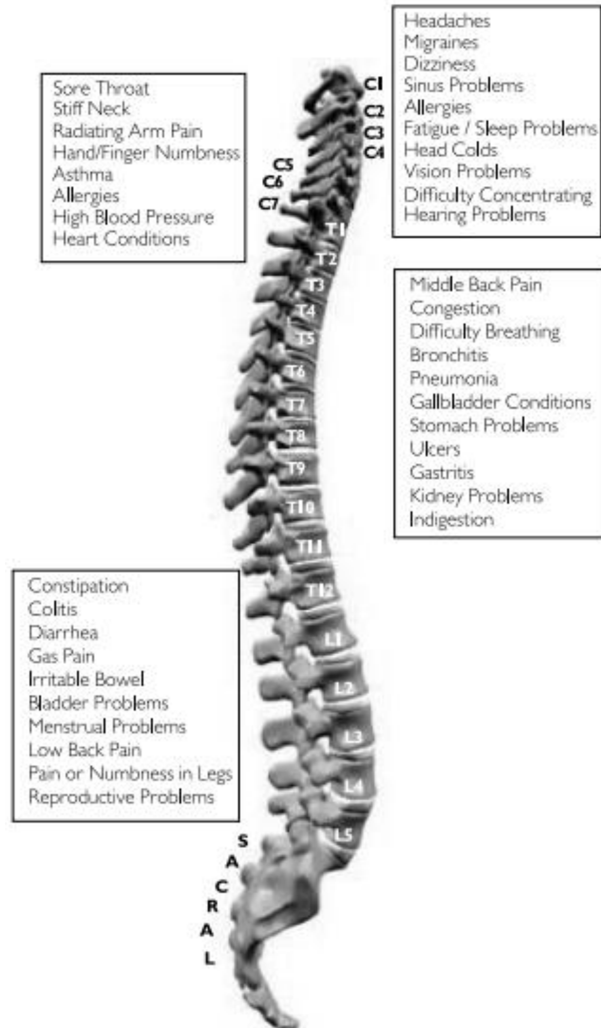
DID YOU KNOW…

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ _______________
- ☐ _______________
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _______________
- ☐ _______________

Explain any boxes checked above:

____

____

____

____

PRENATAL HISTORY (for children < 1 year ONLY)

Location of Birth: Home Birthing Center Hospital Other: ___________________________________

Did any of the following happen during delivery:

C-section delivery - Doctor pulled or twisted the baby - Anesthesia - Labor was induced

Forceps/vacuum extraction - Premature delivery - Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

____

Did you experience any illness while pregnant? Yes No If yes, explain: _________________________________

Do you have any physical disabilities? Yes No If yes, explain: ____

Birth weight: _________________ Birth Length: __________________ APGAR scores (if remembered): ___________

Ultrasound used during pregnancy? Yes No Number of times: _________

Did you breastfeed the baby? Yes No If yes, how long: _________

Did you formula-feed the baby? Yes No If yes, how long: _________

At what age did you introduce: Solids: ___________ Cow's milk: ___________

LIFESTYLE HABITS (for children > 1 year ONLY)

Does your child exercise daily? Yes No How much? ____

Does your child drink soda? Yes No How much/often? ____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much? __________________________

Does your child eat balance meals? Yes No

Does your child experience prolonged sadness? Yes No Explain: ______________________________________

Does your child have difficulty sleeping? Yes No Explain: ____

Does your child play video games? Yes No How much? ____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing tables, stairs, etc.). Was this the case for your child? Yes No Explain: _______________

Has your child ever been hospitalized or had surgery? Yes No Explain: ______________________________

Does your child have difficulty interacting with others? Yes No Explain: _____________________________

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No

Explain: ____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?

Yes No Please list: ____

Are you aware of any food allergies or intolerance? Yes No Explain: __________________________________

Has your child received all recommended vaccinations? Yes No Explain: _______________________________

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian)_______________________________________ , give Pure Chiropractic and Wellness permission to examine, and treat (Child) ____.

Minor date of birth: _________-__________-___________

Parent/Guardian Signature: ____ Date: _________________________

Witness Signature: ____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- I authorize Pure Chiropractic and Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.
- If the patient's parents are divorced, divisions of your child's treatment costs are the parent's responsibility. We do not split contracts. In signing, you are taking financial responsibility for your child's account payments.

Parent/Guardian Signature: ____ Date: _____________

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures by Dr. Heather Rogers King and her staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Pure Chiropractic and Wellness personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Pure Chiropractic and Wellness will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Pure Chiropractic and Wellness responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my child's present condition and for any future care provided by this clinic and/or employed staff.

Parent/Guardian Signature: ____ Date: _____________

Witness Signature: ____ Date: _____________