Tobin
Family Chiropractic

# PEDIATRIC INTAKE FORM

Today's Date: _____

Patient Name _____ Date of Birth _____ Sex: M F

Siblings and ages: _____

Has patient ever had chiropractic care? Y N If yes, Dr's Name:_____

(If yes, approximate Dates of Chiropractic Care: _____)

**Parent/ Guardian Name(s):** _____

Address _____

Town _____ State _____ Zip _____

Best number to reach parent _____ Alt Phone Number _____

Email(s) (to notify of changes in office hours) _____

## MAIN COMPLAINT / REASON FOR THIS VISIT:_____

_____

Please list all testing/treatments/procedures/medications for this complaint: _____

_____

Date of onset: _____ Onset (circle): Sudden Gradual Traumatic Unknown cause

What makes the symptoms worse? _____

What makes the symptoms better? _____

Are there any other details about your child's health that you would like to discuss? _____

_____

# PRENATAL HISTORY

Gestational Duration: _____ weeks. Complications during pregnancy: YES NO

If Yes, please elaborate: _____

Type of Birth (circle all that apply): Normal Vaginal Prolonged Labor (_____ hours)

Forceps/Vacuum Breech Planned C-Section Unplanned C-Section Emergency C-section

Childhood Diseases:

Please list: _____

Has your child had ear infections? YES (how many? _____) NO

Has your child had antibiotics? YES (how many courses? _____) NO

Has your child suffered any childhood injuries or sports injuries? YES NO

_____

Has your child had any serious condition, illness, hospitalizations or surgeries? _____

_____

Please list all medications, vitamins and/or nutritional supplements taken: _____

_____

Please list any and all allergies (food, environmental, medication) _____

Authorization for Care of a Minor: I hereby authorize Dr. Dawn Tobin and whomever she may designate to administer care as they deem necessary to my child.

Signed: _____ Date: _____

I have provided the staff with my most recent insurance card: (please circle) YES NO

DOCTOR'S COMMENTS: _____

_____

_____

_____

_____