KehoeFamily Chiropractic
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It is easier to RAISE a HEALTHY CHILD, than it is, to treat a sick one.

PEDIATRIC INTAKE FORM

Child's Name: _____ **AGE:** _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:**_____ **ZIP:**_____
Parent's/Guardian Name: _____ **Home #**_____
Email:_____ **Cell#**_____
Parent's DOB_____

Health History

Did you have any complications during pregnancy? ❍ no ❍ yes **IF yes, Please describe:**
_____

DELIVERY: ❍ No Complications ❍ Vaginal ❍ Forceps/ vacuum ❍ Breech ❍ Cesarean
LOCATION: ❍ Home ❍ Birthing Center ❍ Hospital ❍ Doula ❍ Mid-wife
Name of OBSTETRICIAN/MID-WIFE: _____
BIRTH WEIGHT:_____ **BIRTH LENGTH:** _____
APGAR SCORE: _____ **Presence of:** ❍ Jaundice ❍ Cyanosis (blue)

INFANTILE FEEDING: ❍ Breast **How long?** _____ ❍ Bottle ❍ Formula
CONGENTIAL ABNORMALITIES: _____
Date of last medical visit: _____ **Purpose:**_____
IMMUNIZATION HISTORY: ❍ Never received shots ❍ Received shots (please list)
_____

Noticed any complications/difficulties/reactions after shots? ❍ no ❍ yes ❍ yes * If Yes or unsure please describe: _____
Has your child ever been treated on an emergency basis? ❍ no ❍ yes **(describe)**
_____

Does your child drink milk? ❍ no ❍ yes **If yes, How much**? _____/ day
What type of milk? ❍ Organic ❍ Whole milk ❍ 2% ❍ 1 % ❍ skim **OTHER:** _____
Has your child ever been on antibiotics? ❍ no ❍ Yes **How many times?** _____
Has your child recently been or currently on any medications including over the counter medication? ❍ Yes ❍ No **Please list:**_____
_____

Has your child suffered from: ❍Colic ❍ Ear Infection ❍ Asthma ❍ Recurrent Colds
❍Chronic Cough ❍ Chronic Runny nose ❍ Constipation

Has your child been in an auto accident, suffered a fall or been involved in any physical trauma?
❍ Yes ❍ No
If yes Please Describe: _____

Current Condition

Is your child here for: ❍ **Wellness Checkup** ❍ **Specific Condition**
Please Explain: _____
How long has your child had this condition?_____ **Is this the first time ?** ❍ yes ❍ no
What activities aggravate their condition? _____
Does their condition seem to be getting worse? ❍ Yes ❍ No
Who else has your child seen for this condition: _____ When ? _____
What reaction has your child had to past treatments for this? _____
Has your child ever had a chiropractic check-up before? ❍ **yes** ❍ **no When?** _____