Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz

Newborn - Preschooler (0-6 y/o)
Chiropractic Intake form

Welcome to our office!! The following information is confidential. It will be used to complete your history and understand your condition, so please be as accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION Date ____/____/____

Patient Name _____
LAST FIRST MI

Date of birth _____/_____/_____ Age _____ Height_____ Weight_____lbs. Sex ☐Male ☐Female

Address _____

City _____ State _____ Zip _____

Parent/Guardian Name(s)_____

Cell Phone (_____)_____ Work Phone (_____)_____

Home Phone (_____)_____ Best time to reach you _____

Parent/Guardian email_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Primary Phone (_____)_____ Secondary Phone (_____)_____

REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family/Friend (Whom may we thank for referring you? _____)

☐ Internet Search ☐Primary Physician ☐ Staff ☐ Other _____

Can we send them a thank you note for referring you to us? ☐ Yes ☐ No

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name_____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature:_____ Date ____/____/____

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PATIENT CONDITION

What health condition(s) bring your child to be evaluated by a chiropractor:_____
_____

When did this condition begin?_____/_____/_____ How did the problem start: □ Suddenly □ Gradually □ Post-Injury

How often does your child experience this condition? □ Constant □ Frequently □ Intermittent □ Occasionally

Does this condition interfere with □ Sleep □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Has your child received treatment for this condition before? □ No □ Yes

If yes, please explain_____

What makes the problem better?_____ What makes the problem worse?_____

HEALTH GOALS

What are the top 3 health goals for you child?

1._____

2._____

3._____

What would you like to gain from chiropractic care?

□ Resolve existing condition □ Overall Wellness □ Both

PREVIOUS TREATMENT

Pediatrician_____ Date of last visit_____/_____/_____

Previous Chiropractic Care: □ No □ Yes Name:_____ Date of last visit_____/_____/_____

Other Health Care Professional_____

Previous Diagnosis_____

HEALTH HISTORY

Please mark any of the following conditions that your child currently experiences or has ever had

□ Abnormal bleeding
□ Allergies
□ Asthma/Wheezing
□ Bedwetting
□ Cancer
□ Chicken Pox
□ Child doesn't get along well with other Children
□ Discipline problems
□ Eczema/Skin Problems
□ Emotional problems
□ Ever eating dirt, paint or plaster
□ Eye problems
□ Frequent colds or sore throats
□ Frequent ear infections
□ HIV/AIDS
□ Irritable/temper problems
□ Kidney/Bladder problems
□ Mouth breather/snoring
□ Mumps, Measles
□ Nightmare/sleep problems
□ Night sweats

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HEALTH HISTORY (cont...)

☐ Colic	☐ Handicaps/Disabilities	☐ Pneumonia
☐ Congenital heart defect	☐ Hearing problems	☐ Reflux
☐ Convulsions/Epilepsy	☐ Heart murmur	☐ Rheumatic Fever
☐ Croup	☐ Hemophilia	☐ Speech problems
☐ Dental problems	☐ Hepatitis	☐ TB/Lung Disease
☐ Developmental problems	☐ High Blood Pressure	☐ Thumb sucking
☐ Diabetes	☐ High Cholesterol	☐ Toilet training problems
☐ Diarrhea or Constipation	☐ Oral Thrush	☐ Jaundice

☐ Other _____

Please explain any medical issues that your child has: _____

_____

LABOR & DELIVERY HISTORY

Child's birth was? ☐ Natural Vaginal Birth ☐ Scheduled C-Section ☐ Emergency C-Section

Child's birth was. ☐ At home ☐ At a birth center ☐ At a Hospital ☐ Other_____

At how many weeks was your child's birth? _____ Birth weight_____ Birth height_____

Please check any applicable interventions or complications

☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction ☐ Forceps

Were any of the following used throughout pregnancy? ☐ Doula ☐ Midwife ☐ Chiropractor

Any evidence of birth trauma? (Bruises, odd shaped head stuck in the birth canal, fast or excessively long birth, respiratory depression, cord around the neck, other)_____

FAMILY HISTORY (*any parents, siblings, grandparents, aunts & uncles have the following?)*

Mark all that applies

☐ Diabetes	☐ Heart Disease	☐ Hight blood pressure	☐ Stroke
☐ Breast Cancer	☐ Ovarian Cancer	☐ Colon Cancer	☐ High Cholesterol
☐ Blood Clots	☐ Mental Illness	☐ Osteoporosis	☐ Blood disorders
☐ Uterine cancer	☐ Cancer (other)_____		

☐ Other_____

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GROWTH & DEVELOPMENTAL HISTORY

Was/Is the child breastfed? ☐ No ☐ Yes If yes, how long?_____ Difficulty with breastfeeding? ☐ Yes ☐ No

Did/does your child ever use formula? ☐ No ☐ Yes If yes, at what age?_____ If yes, what type?_____

Does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ No ☐ Yes

At what age did the child: Respond to sound_____ Follow an object_____ Hold their head up_____

Vocalize_____ Teethe_____ Crawl_____ Walk_____ Begin cow's milk_____ Begin solid food_____

Known food sensitivities/allergies_____

Typical diet ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Number of meals each day_____ Number of snacks per day_____

Has your child been vaccinated? ☐ Yes. ☐ No If yes, which ones and list of reactions to them if any_____

_____

_____

GROWTH & DEVELOPMENTAL HISTORY (cont…)

Has your child ever been on any antibiotics? ☐ No ☐ Yes How many courses_____

List any medication, vitamins, herbs, minerals your child is currently taking?_____

_____

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates: _____

_____

How often is your child using screen time? (Cell phone, iPad, computer/laptop, television) Hours per day_____

Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. _____(initials)

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in. being charged the cost of the appointment_____(initials)

NOTICE OF PRIVACY PRACTICE *We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at (360) 352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. _____(initials)*

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Informed Consent

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need, you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft tissue manipulation, nutritional recommendations, and exercise. Please list any preferences here_____

I have read the previous information regarding the risk of chiropractic care, and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this care plan, understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing, I give consent for examination, tests, and procedures for the above minor patient. _____(initials)

By signing, I have read and understood the Office Policies and Informed Consent:

Print Patient Name _____

Print Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____/_____/_____