MORTER Wellness Center

Pediatric Intake Form (Birth to 12 years)

Patient Information:

Date: _____

Child's Name:_____ DOB:_____

Parent / Guardian's Name:_____

Home Phone #:_____ Cell Phone #:_____

Address:_____

E-mail Address:_____

Has your child been checked by a Doctor of Chiropractic? ○ Yes ○ No

If yes, please provide the name of the office & doctor._____

Were x-rays taken ○ Yes ○ No

Who is your medical pediatrician?_____

Prenatal History:

Is your child adopted? ○ Yes ○ No

Did you have any complications and when?

Did you smoke? ○ Yes ○ No

Did you consume alcohol? ○ Yes ○ No

Did you take medication? ○ Yes ○ No

Reason for the medication?_____

Birth History:

Did you have ultrasound during this pregnancy? ○ Yes ○ No

What was the frequency?

Place of Birth: ○ Home ○ Birthing Center ○ Hospital

Provider: ○ Midwife ○ OB-Gyn ○ Other

Type of Birth: ○ Vaginal ○ C-section

Were pain medications used? ○ Yes ○ No

Was labor induced? ○ Yes ○ No

If yes, why? _____

What position did you deliver in? ○ Squatting ○ On back ○ Other

Birth Trauma? ○ Doctor assisted ○ Twisting and/or Pulling ○ Vacuum ExtractionForceps

Newborn trauma (medical procedures and tests): _____

APGAR score: birth ____/10 5-minutes ____/10 Unsure

Did your child have a misshaped skull / head? ○ Yes ○ No

Were there purple markings on their face? ○ Yes ○ No

Did you breast feed your child? ○ Yes ○ No

Does your child prefer one breast over the other? ○ Yes ○ No

If yes, which side ○ Right ○ Left

Does your child have any food allergies? ○ Yes ○ No

If yes, please list:_____

Has your child been immunized? ○ Yes ○ No

Reason for vaccination? ○ Informed decision ○ Recommended ○ Didn't know I had a choice.

Did your child have any negative reaction to the vaccinations? ○ Yes ○ No

Were they reported? ○ Yes ○ No

Has your child ever had any surgeries? ○ Yes ○ No

If yes, please elaborate. _____

Has your child been on antibiotics? ○ Yes ○ No

If yes, how often and what for?

Is your child currently taking any medication? ○ Yes ○ No

Is your child currently taking any vitamins? ○ Yes ○ No

Has your child been diagnosed with a tongue or lip restriction? ○ Yes ○ No
Has it been revised? ○ Yes ○ No

Name of Doctor who performed the surgery: _____

Date of surgery: _____

Baby / Toddler (0-4):

Have any of the following occurred?

- ○ Fall from a changing table
- ○ Frequent crying spells
- ○ Tumble down stairs
- ○ Involvement in MVA
- ○ Fall out of crib
- ○ Fall off of playground equipment
- ○ Play in a Johnny Jumper
- ○ Frequent ear infections
- ○ Tonsillitis
- ○ Reaction to vaccines
- ○ Frequent fevers
- ○ Frequent diarrhea
- ○ Constipation
- ○ Sleeping problems
- ○ Repeated infections
- ○ Colic or colds
- ○ (+ or -) weight gain
- ○ Other (Please explain):

Child (5-12):

Have any of the following occurred?

- ○ Fall from a tree
- ○ Fall off of a bicycle
- ○ Sports accident
- ○ Car accident
- ○ Stomach pains
- ○ Scoliosis
- ○ Bed wetting
- ○ Fall on playground
- ○ Hyperactivity / Autism
- ○ Learning difficulties
- ○ Asthma
- ○ Allergies
- ○ Leg / Knee pains
- ○ Other (Please explain):
- ○

Which of the above bothers your child the most?

When did it begin?

Is it getting worse? ○ Yes ○ No

Is the pain: ○ Constant ○ Intermittent ○ Cyclic

Effect on activity? ○ Not at all ○ Somewhat ○ Always

Does your child participate in any of the following?

- ○ Soccer
- ○ Football
- ○ Gymnastics
- ○ Karate
- ○ Hockey
- ○ Lacrosse
- ○ Basketball
- ○ Dance
- ○ Wrestling
- ○ Baseball / Softball
- ○ Volleyball
- ○ Tennis
- ○ Swimming
- ○ Rugby
- ○ Other

How would you rate your child's diet? ○ Well balanced ○ Average ○ High sugar/Processed foods

Does your child consume artificial sweeteners? ○ Yes ○ No

Fluoridated water? ○ Yes ○ No

Number of hours your child sleeps? _____hours per day

Sleep Quality? ○ Good ○ Fair ○ Poor

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Authorization to treat a Minor

I, _____the undersigning parent/guarding having legal custody/guardianship of - _____, a minor, do hereby authorize, request and direct Dr. Palmer and whomever she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: _____ Signature: _____

Print Name *Parent / Legal guardian*