



## CHILD /MINOR INTAKE

Child's Name: \_\_\_\_\_ Sex: F M DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

What are your health objectives for your child? \_\_\_\_\_

### REASON FOR THIS VISIT

-Reason for Visit: Wellness Condition → If condition, please explain: \_\_\_\_\_

-Is the condition a result of Sports Auto Fall Home Injury Other : \_\_\_\_\_

-Has this condition happen before? Yes No → If yes, how many times? \_\_\_\_\_ How long did it last? \_\_\_\_\_ How long did it take? \_\_\_\_\_ Types of interventions /treatments used? \_\_\_\_\_

-Have you seen any other professional for this condition? Yes No → If yes, who and what was the result of treatment? \_\_\_\_\_

-Previous Chiropractor: Yes No → If yes, date of last Visit: \_\_\_\_\_

-Reason for Visit: \_\_\_\_\_

-Name of Pediatrician: \_\_\_\_\_ -Date of last Visit: \_\_\_\_\_

### MEDICATION / VACCINATION HISTORY

-Number of doses of prescription medications your child has taken during his/her lifetime: \_\_\_\_\_

-Please list all medications: \_\_\_\_\_

-Vaccination history: DPT MMR Chicken Pox Hepatitis Other: \_\_\_\_\_

-Has your child ever had a reaction to any vaccination? Yes No If yes, please list the vaccination and reaction: \_\_\_\_\_



**CURRENT HEALTH STATUS**

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., bed, changing table, down stairs, etc.).

-Was this the case with your child? Yes No → If yes, please describe: \_\_\_\_\_

-Is/has your child been involved in any high impact or contact type sports? (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.) Yes No → Please list: \_\_\_\_\_

**PRE-NATAL HISTORY**

-Name Midwife/ Obstetrician: \_\_\_\_\_

-Complications during pregnancy? Yes No → If yes, list here: \_\_\_\_\_

-Medications during pregnancy? Yes No → If yes, list here: \_\_\_\_\_

- Cigarette/ Alcohol use during pregnancy? Yes No -Ultrasound during pregnancy? Yes No

-Location of Birth: Home Birthing Center Hospital

- If hospital or birthing center yes, provide the name please: \_\_\_\_\_

-Birth Intervention: None Water Forceps Vacuum Extraction Caesarian Section

-If C-Section, was it; Emergency Planned?

-Complications during delivery? Yes No → If yes, list here: \_\_\_\_\_

-Genetic disorders or disabilities?Yes No → If yes, list here: \_\_\_\_\_

- Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

**FEEDING HISTORY**

-Breast Fed: Yes No -How Long: \_\_\_\_\_ -Formula Fed: Yes No -How Long: \_\_\_\_\_

-Introduced to solids at: \_\_\_\_\_Months -Introduced to cow's milk at: \_\_\_\_\_Months

-Food/ Juice allergies or intolerance?Yes No → If yes, please List: \_\_\_\_\_



**DEVELOPMENTAL HISTORY**

-Difficulties with your child’s development? Yes  No → If yes, please List: \_\_\_\_\_

-Please check (✓) N/A for not applicable, “P” for past and “C” for current for all symptoms your child has ever had, even if they do not seem related to your current problem.

<i>Symptom</i>	<i>N/A</i>	<i>P</i>	<i>C</i>	<i>Symptom</i>	<i>N/A</i>	<i>P</i>	<i>C</i>
Ear Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upset Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyper activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: \_\_\_\_\_

- Does your child in general; Exercise daily? Eat balanced Meals? Takes vitamins?
- Play video games? Drink water daily? Drink soda? Takes medication?
- Has difficulty sleeping? Watch more than an hour of TV a day?

-Is your child in general: Happy Often sad Is overweight Other:\_\_\_\_\_

- What does your child likes to spend time doing?\_\_\_\_\_

**FAMILY HEALTH PROFILE**

-At this office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please list any concerns you have about any of your family members.



Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Brother(s): \_\_\_\_\_ Sister (s): \_\_\_\_\_

Note: \_\_\_\_\_

-Please check yes or no whether the condition exists in your family. If yes; check "M" if on mothers side of the family, "F" for fathers side of the family and "S" for siblings. Does any member of your immediate family suffer from:

Conditions	Yes	No	S	M	F	Condition	Yes	No	S	M	F
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

-Any additional information you would like to share? \_\_\_\_\_

-Please mark an "X" where you believe your child's health is and an "O" where you would like to be.

\_\_Very Challenged      \_\_Challenged      \_\_Transition      \_\_Good      \_\_Excellent

-I consent to a professional and complete Chiropractic evaluation and to any other evaluations such as x-rays, blood work and or nutritional evaluation that the doctor deems necessary.

**CONSENT TO EVALUATE AND ADJUST A MINOR**

I, \_\_\_\_\_ being the parent / legal guardian of \_\_\_\_\_ do hereby grant permission to Dr. Marina Zaré to perform chiropractic services to my son / daughter listed above.

Parent / Guardian's Name & Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Thank you for the opportunity to serve you!*

Office use only

PT: DR EX AM AN    VO: TPR CC WC    HI: 1 2 3 4 5 6 7 8 9 10    WI:

PTG: \_\_\_\_\_