Welcome To

Precise Chiropractic

4101 John R. Rd Suite 300 • Troy, MI 48085 • (248) 680-7200

Pediatric Intake Form

Patient (Child) Information:

Child's Name: ____ Date: ___________________________

Address: _______________________________________ City: _________________ State:_______ Zip:__________

Sex: Male Female Date of Birth: ________________ Age: _______ Height: ___________ Weight: ____________

Name of Parents/Guardians: _________________________________ Email: ______________________________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: ___________________

Whom may we thank for your referral?: _________________________________

General Questions/ Prenatal History:

Birthing Intervention: ❑Normal Vaginal ❑Forceps ❑Cesarean ❑Suction Cap or Vacuum

Is your child adopted? ❑Yes ❑No

Problems during pregnancy: ____

Problems during labor/delivery: ____

Immunization history: ____

Number of doses of antibiotics your child has taken: During the past 6 months ________ During his/her lifetime_______

At what age, if ever, did this child suffer from the following childhood diseases?

❑Chickenpox_____ ❑Mumps_____ ❑Measles_____ ❑Rubella_____ ❑Rubeola_____ ❑Whooping cough_______

❑Other______________________

Present Complaint(s):____

When did this begin?: ___________________________________ Was there an accident/injury involved? ❑Yes ❑No

Has your child had any past treatment for this complaint?: ❑Yes ❑No Describe:________________________________

Has this child ever suffered from:

❑Headaches	❑Orthopedic Problems	❑Digestive Disorders	❑Behavioral Problems
❑Dizziness	❑Neck Problems	❑Poor Appetite	❑ADD/ADHD
❑Fainting	❑Arm Problems	❑Stomach Aches	❑Ruptures/ Hernia
❑Seizures/Convulsions	❑Leg Problems	❑Reflux	❑Muscle Pain
❑Heart Trouble	❑Joint Problems	❑Constipation	❑Growing Pains
❑Chronic Earaches	❑Backaches	❑Diarrhea	❑Learning Difficulties
❑Sinus Trouble	❑Poor Posture	❑Diabetes	❑Sleeping Troubles
❑Asthma	❑Scoliosis	❑Hypertension	❑Allergies:__________
❑Colds/Flu	❑Walking Trouble	❑Anemia	❑Other ____________
❑Colic	❑Broken Bones	❑Bed Wetting	❑Other ____________

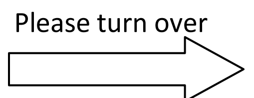
Has this child ever suffered from the following spinal traumas?

❑Fall in baby walker	❑Fall from bed or couch	❑Fall off skateboard or skates
❑Fall from crib	❑Fall off swing	❑Fall off bicycle
❑Fall from highchair	❑Fall off slide	❑Fall down stairs
❑Fall from changing table	❑Fall off monkey bars	❑Other ________________________

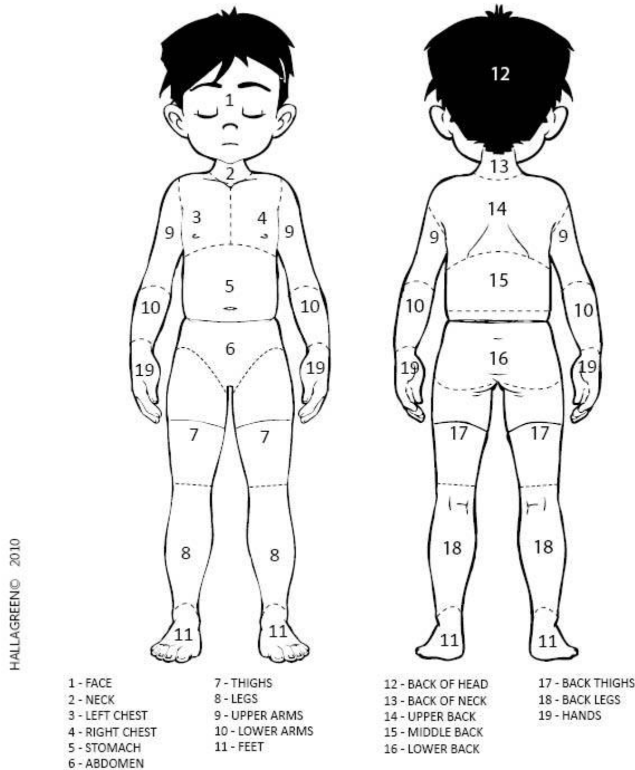
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc.). Was this the case with your child? ❑Yes ❑No

Explain: ____

Please turn over



Has this child ever sustained an injury playing organized sports? If yes, please explain: ___________________________
____
Has this child ever sustained injuries in an auto accident? If yes, please explain: _________________________________
Has this child ever broken/fractured any bones? Explain____
Has this child ever received stiches not related to surgery:____
Other traumas not described above: ____
Surgeries: ____
Medications: ____
Present history: ____
Purpose of this appointment: ____



AUTHORIZATION FOR CARE FOR MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of guardian).

Signed: ______________________________Witnessed: ______________________________Date: _________________

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

Signed: ______________________________ Date: _________________