



SUMMIT KIDS

Initial/Confidential Intake Form

Child's Name: _____ Date: **D** ____ **M** ____, 2**00**__

Parents' /Guardians' Names: _____

Home Phone: _____ Parent's Cell: _____

Home: _____

City: _____ PC: _____ Birth Date: **D** ____ **M** ____ **Y** _____

Age: ____ Sex: M F Previous Chiropractic Care? YES NO Approximate Last Visit: _____

Email address: _____ MSP Number: _____

Reasons for Seeking Chiropractic Care

Please check reasons for pursuing chiropractic care for your child:

- ____ He/She is continuing ongoing care from another chiropractor.
- ____ I recently had my spine checked and see the value in getting my child checked.
- ____ I'm concerned about his/her health and I'm looking for answers.
- ____ He/She has a specific condition that concerns me.
- ____ I want to improve my child's immune function.

Many of the common health challenges that occur later in life have their origins during the developmental years, some starting at birth. Certain stresses in life start to produce layers of damage to the spine and nervous system. Please answer the following questions, about your child, to the best of your ability.

Child's Current Body Signals

Please check any of the following body signals which he/she has or has *had* previously:

- | | | |
|---|--|---|
| <input type="radio"/> Headaches/Migraines | <input type="radio"/> Frequent Crying Spells | <input type="radio"/> Did not gain weight |
| <input type="radio"/> Asthma | <input type="radio"/> PDD/Autism | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Sleep Problems | <input type="radio"/> Seizures | <input type="radio"/> Car Accident |
| <input type="radio"/> Weight Problems | <input type="radio"/> Frequent Colds | <input type="radio"/> Colic |
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Allergies | <input type="radio"/> Digestive Problems |
| <input type="radio"/> Poor Posture | <input type="radio"/> Sinus Problems | <input type="radio"/> Scoliosis |
| <input type="radio"/> Constipation | <input type="radio"/> Bedwetting | <input type="radio"/> Back Problems |
| <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Ear Infection | <input type="radio"/> Other: _____ |

Which of the problems that you have checked off is the worst: _____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____



Prenatal History

Adopted YES NO

Complications during pregnancy? YES NO Explain: _____

Any exposure to ultrasound during pregnancy? YES NO Number: _____

Medications/drugs/caffeine use during pregnancy? YES NO List: _____

Cigarette/Alcohol use during pregnancy? YES NO

Location of birth: Hospital Birthing Center Home Other: _____

Birth History

Complications during delivery? YES NO If yes: Forceps Cesarean Breech Vacuum
 Mother Induced Mother medicated (Epidural, Pitocin, etc.) Baby given medication
 Other: _____

Genetic Disorders or Disabilities? YES NO List: _____

Breast Fed? YES NO How Long? _____ Formula Fed? YES NO How Long? _____

Food or Other Allergies? YES NO List: _____

What was the baby's APGAR Score at 1 minute? ____ /10 & at 5 minutes? ____ /10 Unsure
Was there initial respiratory delay? YES NO Purple markings on face? YES NO

Mis-shaped skull/head? YES NO

Vaccination History

If you vaccinated, what vaccinations and age given? _____

Any negative reactions? YES NO List: _____

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

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child? YES NO List: _____

Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, martial arts, etc.)? YES NO List: _____

Has your child been seen in an emergency room? YES NO List: _____

Any Surgeries? YES NO List: _____

Consent to evaluation of a minor child

I _____ being the parent or legal guardian of _____
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation by Dr. Wiebe and his associates and they have my permission to perform an X-ray evaluation, if necessary.

Consenting Adult's Signature

Date

