Whom may we thank for referring you to this office? _____

PEDIATRIC INTAKE FOR CARE AT LAKE NONA FUNCTIONAL CHIROPRACTIC

Today's Date: _____ CTN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐Male ☐Female

Address: _____

City: _____State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Mother's Email: _____ Father's Email: _____

Home Phone: _____Mother's Work/Cell: _____ Father's Work/Cell: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Name & Number of Emergency Contact: _____Relationship: _____

Birth Weight: _____ Current Weight: _____ Birth Length: _____ # of Siblings: _____

Type of Birth (circle all that apply): Normal vaginal Forceps Breech Cesarean

Child's Congenital Anomalies/Defects: _____

Family History of Congenital Anomalies/Defects: _____

Birthing Location (Circle all that apply): Home Birth Birthing Center Hospital: _____

Pregnancy History/Problems during pregnancy: _____

_____

APGAR score: _____ Was there presence of: _____ Jaundice (Yellow) _____Cyanosis (Blue) ?

Infant Feeding: Breast: _____ # of months _____ Bottle: _____ # of months

Formula: _____ # of months _____ Brand(s): _____

Number of hours of sleep per night: _____ Quality of sleep (circle): Good Fair Poor

Immunization History: _____

Developmental History – At what age did the child:

_____ mo/yrs follow an object with their eyes _____ mo/yrs respond to sound _____ mo/yrs sit unaided

_____ mo/yrs stand unaided _____ mo/yrs Hold head up _____ mo/yrs walk unaided

_____ mo/yrs crawl

For Administrative Use Only

Patient's Name: _____ CT#: _____ ____/____/____

Childhood Diseases (Check all that apply):

_____ Chicken Pox _____Rubella _____ Rubella

_____Measles _____ Mumps _____ Whooping cough

Other: _____

Reasons for this visit: _____

Activities of Daily Living/Symptoms/Medications

Has the child ever suffered from (check all that apply):

___ Diabetes	___ Convulsions/Epilepsy	___Rheumatic fever	___Walking problems
___ Poor appetite	___Tremors	___Hypertension	___Paralysis
___Joint Problems	___Hyperactivity	___ Sinus trouble	___Fainting
___ Shoulder pain	___Blood disorders	___Anemia	___Heart problem
___Tuberculosis	___Allergies	___Neck problems	___ Stomach aches
___ Ruptures/hernia	___Dizziness	___Digestive problems	___Leg problems
___Diarrhea	___Bed wetting	___Broken bones	___Constipation
___ Neuritis	___ Headaches	___ Arm problems	___ Behavioral problems
___ Frequent Colds/Flu	___Backaches	___ Asthma	

Others: _____

Present history and allergies: _____

_____

Surgeries: _____

Accidents: _____

Medications: _____

Family History: _____

I hereby authorize payment to be made directly to Lake Nona Functional Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Lake Nona Functional Chiropractic for any and all services I receive at this office.

_____ _____/ _____ /_____

Authorized Person's Signature **Date Completed**

_____ _____/ _____ /_____

Doctor's Signature **Date Form Reviewed**