Today's Date: _____

TWO RIVERS
CHIROPRACTIC

Pediatric Patient Intake Form

Welcome! Your first visit to our clinic is an opportunity for us to learn all about you and your family. Please share with us where you are now in your health & life.

Personal Information

Legal Name:_____ Preferred Name: _____

Sex:_____ Gender:_____

Age:_____ Date of Birth:_____ Height:_____ Weight: _____

Parent's Names:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (___)_____ Work Phone: (___) _____ Cell Phone: (___)_____

Email Addresses: _____

Parents are ☐ Single ☐ Married/Partnered ☐ Divorced ☐ Widowed

# of Kids:_____ Names & Ages of Children: _____

_____

How did you hear about us?

☐ Website ☐ Google ☐ Social Media ☐ Event: _____

☐ Referral- Who can we thank for referring you?_____

☐ Other: _____

Let's find out why you're here…

What concerns do feel Two Rivers Chiropractic can address for your child? _____

_____

Related to: ☐ Sports ☐ Auto ☐ Fall ☐Chronic ☐ Home injury ☐ Other:_____

Are these concerns affecting your child's quality of life? (please check all that apply)

☐ Communication ☐ School ☐ Fitness/Sports ☐Playing ☐ Walking

☐ Attention/Focus ☐ Eating ☐ Daily Routine ☐ Sleep ☐Other: _____

Health Care Practitioner History

Has your child ever been to a Chiropractor before? □ No □ Yes Name of DC:_____

How long has your child been under care? _____ Date of last visit:_____

Is your child under care with any other doctor or healthcare provider?

□ No □ Yes Name of healthcare provider:_____

The information below will help us to see the types of **PHYSICAL, EMOTIONAL, & CHEMICAL** stresses you have been subjected to in your life, and how they may relate to present spinal nerve health status to determine whether they may have contributed to a neurospinal dysfunction.

Pregnancy & Birth

During pregnancy, did the mother:

□ Experience any significant illnesses, difficulties or trauma?_____
□ Take any drugs/medications (Rx or OTC)? _____
□ Smoke or Consume Alcohol _____

Please rate mother's general stress level during pregnancy: 1 2 3 4 5 6 7 8 9 10

The birthing process can be traumatic to a baby's spine and cause damage to the neural spinal system. Please CHECK all that apply regarding your child's birth.

□ Home □ Hospital □ Natural □Caesarian section □ Forceps □ Breech
□ Vacuum □ Epidural □ Pitocin □Prolonged Labor □ Manual Traction of the neck
□ Cord around neck □ Other medications or complications: _____

Was the delivery premature? □ No □ Yes Weeks:_____ Birth Weight:_____

Duration of labor: _____ hours

Please check all that apply to your baby's status immediately after birth:

□ Jaundice □ Respiratory problems □ Feeding problems □Displaced joints
□ Broken bones □ Other conditions: _____

□ Was the baby Breastfed? □ No □ Yes For how long? _____
Please describe your breastfeeding experience? _____
_____

Physical Stress:

Please check all that apply to your child & give any necessary or relevant details

□ Had a severe trauma _____
□ Has been hospitalized _____
□ Been in an automobile accident _____

☐ Has fractured a bone or dislocated a joint_____
☐ Has a chronic illness _____
☐ Has had surgery _____
☐ Other: _____

What physical activities does your child participate in? _____
_____

Emotional Stress:
Please indicate if your child is currently experiencing (C), has experienced in the past (P) or has the possibility of experiencing this stressor in the future (F)

	C	P	F		C	P	F
Academic pressure	☐	☐	☐	Parents' divorce	☐	☐	☐
Lifestyle change	☐	☐	☐	Loss of a loved one	☐	☐	☐
Relocation	☐	☐	☐	Loss of a pet	☐	☐	☐
New sibling	☐	☐	☐	Bullying	☐	☐	☐

Does your child have difficulties interacting with schoolmates or friends? ☐ No ☐ Yes
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behaviors? ☐ No ☐ Yes
If so, please describe: _____
_____

Chemical Stress:
Common chemical stressors include food allergies, drug reactions, exposure to chemicals in the air, etc. The following will reveal exposures your child may have experienced.

Please check all that apply & provide any relevant details:
☐ Child exposed to second-hand smoke. Where? _____
☐ Frequently taken antibiotics. Most recent date: _____
☐ Currently taking medications. List: _____
☐ Currently taking supplements. List: _____
☐ Has allergies. Explain. _____

What would you like your child to gain at Two Rivers Chiropractic? Check all that apply
☐ Resolution and prevention of a symptoms or problem
☐ Prevention of future problems
☐ Healthier spine and nervous system
☐ Continual progression in health & life

Let's Make Sure We're on the Same Page…
When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not s substitute or alternative for, nor is it a preventive form of medicine. Medically-based care specializes in the ***diagnosis*** and ***treatment*** of specific symptoms, Illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nervous systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function is increased **health, wellness,** and **overall improved quality of life,** we will not diagnose, treat or attempt to cure any specific physical, mental, or emotional aliment, nor will we give advice about specific medication conditions or treatments.

If you are seeking care for the removal of a ***specific*** medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease oriented professional. We suggest this strategy if you feel that our functional-based approach will not be sufficient in progressively raising you to the levels of health, wellness, and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Natalie Cooper, D.C or Dr. Jackson Detrick, D.C to continue with my child's and/or initial consultation and assessment. I also agree to return at a lateral date to allow Dr. Natalie Cooper, D.C or Dr. Jackson Detrick, D.C to conduct their report of findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signature: _____ Date: _____

We sincerely thank you for choosing Two Rivers Chiropractic! We thank you for taking the time to honestly reflect upon, and share your current level of health and well-being, as well as your goals.