7726 Center Blvd SE, Suite 125 Snoqualmie, WA 98065 PH: 425.396.0613 FX: 425.396.0614

Pediatric Intake Form

Date_____

Child's Legal Name

D.O.B SS Sex M F

Mailing Address

City, ST, ZIP

Mother's Name Phone Number

Father's Name Phone Number

Parent's Email(s)

Emergency Contact Name Phone

Sibling(s) Name(s)

Optimal Health Chiropractic communicates via text message and/or email.
Please choose the form of communication you would like us to use.

☐ Text Messages ☐ Email ☐ None

To receive text messages please provide your cell phone number AND WIRELESS PROVIDER.

_____

*Standard messaging rates may apply. Optimal Health is not responsible for any fees.

How did you hear about our office? _____

What is the primary reason for visiting our office? _____

Other concern's regarding your child's health or development?

_____

_____

Have you seen other health professionals for any condition(s) listed above? If yes, Please list their name and phone number below:

_____ _____

_____ _____

Have you been treated for any health condition by a physician in the last year? ☐ Y ☐ N

If yes, please describe: _____

_____

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OPTIMAL HEALTH CHIROPRACTIC

Have any of the following happened to your child? (Please check all that apply) Give approximate date and brief description:

☐ Falls or other injuries ☐ Broken bones or surgeries ☐ Spinal or neck injuries ☐ Knocked unconscious

_____

_____

Was your child injured in an automobile accident? ☐ No ☐ Yes Date: ___/___/___

If yes, was your child riding in a saftey seat? ☐ No ☐ Yes

Where was the seat in the car? ☐ Front Seat ☐ Back Seat ☐ Facing Forward ☐ Facing Backward

Where was the imact on your car?

Front of car:	☐ Front end	☐ Driver's Side	☐ Passenger's Side
Rear end of car:	☐ Rear end	☐ Driver's Side	☐ Passenger's Side
Side of car:	☐ Broadside/Side-swipe	☐ Front half of car	☐ Back half of car

List any bumps, bruises, scrapes, cuts, etc. on your child that were caused by the accident:

_____

_____

Has there been a change in your child's eating habits?	☐ No	☐ Yes
Has there been a change in your child's sleeping habits?	☐ No	☐ Yes
Has there been a change in your child's disposition?	☐ No	☐ Yes
Does your child have a fever of unknown origin?	☐ No	☐ Yes
Does your child have a recent change in "bathroom" habits?	☐ No	☐ Yes
Has your child become restless or irritable?	☐ No	☐ Yes

Pregnancy History (Mother):

(If the child is adopted, answer to the best of your ability)

Did you experience any of the following during your pregnancy?

_____Severe Viral Infection

_____Breech Position During Pregnancy

_____Accident or Infections

_____Smoking

_____Severe Stress

_____Preeclampsia

_____Alcohol Consumption and/or Drug Use

_____Radiation Exposure

_____Hypertension (High Blood Pressure)

_____Toxoplasmosis

_____Uncontrolled Diabetes

_____Toxemia

Exam Notes:

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Birth History:

Did you and/or the child experience any of the following during labor/delivery?

_____Birthing Center
_____Home Birth
_____Cord Around the Neck
_____Fetal Distress
_____The Child was a "Blue Baby"
_____The Child was Premature (2+ weeks)
_____Labor was Induced
_____Elective C-section
_____ Hospital Birth
_____Forceps or Suction Cup Used
_____Long and/or Difficult Labor
_____Emergency C-section
_____Breech Birth
_____The Delivery was Rapid
_____Placenta Previa
_____ Multiple birth? How many?_____

New Born History:

Did or does the child experience any of the following as an infant? (P=Past C=Current)

_____Required Resuscitation/Oxygen
_____Prolonged Jaundice
_____Poor Sleeper
_____Constipation
_____Colic
_____Distorted Skull
_____Difficulty Latching/Sucking
_____Refusal to Nurse on One Side
_____Reflux
_____Birth Trauma

_____Breast Fed _____Formula Fed _____Bottle Fed

Health History:

Has your child ever experienced the following or been diagnosed as having any of the following?

_____Adverse reaction to any vaccination (even if mild).
If yes, Explain_____
_____
_____Allergies to Food
_____Any Surgery
_____Asthma
_____Chemical Sensitivities
_____Chronic Ear Infections/Earaches
_____Constipation
_____Diabetes
_____Diarrhea
_____Digestive Disorders
_____Dizziness
_____Environmental Allergies
_____Epilepsy
_____Fainting
_____Frequent Headaches/Eye Pressure or Discomfort
_____Head Injury
_____Heart Disease
_____Illness Accompanied by a High Fever
_____Irregular Blood Pressure
_____Irregular Sugar Levels
_____Joint or Muscle Problems
_____Meningitis
_____Neck or Back Problems
_____Rheumatic Fever
_____Seizures/Convulsions
_____Serious Fall(s) or Repetitive Falls
_____Serious Illness
_____Sinus Problems
_____Trouble with Bladder Control (Enuresis)
_____Difficulty regulating emotions or mood. If yes, please explain _____
_____
_____
_____Other_____

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OPTIMAL HEALTH CHIROPRACTIC

Developmental History:

Does or did your child have any of the following?

_____Difficulty With Crawling (on all fours)
_____Difficulty Learning How to Ride a Bike
_____Difficulty Learning How to Read
_____Difficulty Using Utensils
_____Difficulty Tying Shoes
_____Poor Hand-Eye Coordination
_____Did Not Crawl on All Fours
_____Appears Clumsy
_____Difficulty With Writing
_____Difficulty Buttoning Clothes
_____Difficulty or Awkward with Walking/Running
_____Difficulty Sitting Still or Paying Attention

At what age did your child start to walk unassisted? _____

Neurological/Other:

Has your child ever been diagnosed by a medical professional with any of the following? If yes, by Whom?

_____

_____Hearing Loss or Impairment
_____Neurological Disorders
_____Obsessive Compulsive Disorder (OCD)
_____ADD/ADHD
_____Dyslexia
_____Visual Impairment
_____Anxiety/Depression
_____Autism/Autism Spectrum Disorder
_____Tourette's Syndrome
_____Other_____

Current/Past Medications and Treatments:

List any medication(s) that your child is taking including name, dosage, frequency: _____

_____

List any supplements that your child takes: _____

_____

_____

List any special dietary needs your child has: _____

_____

List any special services your child is currently receiving at school or privately: _____

_____

List any PREVIOUS chiropractic treatment, medication, or other medical treatment your child has undergone:

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

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Authorization for Care of a Minor

I, _____, authorize _____ D.C., to evaluate and treat my son/daughter _____. I understand that the care given at this office is not intended to diagnose and/or treat any disorders such as ADD, ADHD, Dyslexia, Autism, Autism Spectrum Disorders, or any other specific neurological developmental disorders; nor will I or my insurance company be billed as such. Treatment will be that of evaluating and providing chiropractic care for the presence of vertebral subluxation of the spine, and, if necessary, recommending various appropriate exercises to promote proper neurological function and/or development. I acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are the property of this clinic.

_____ _____

Signature of Parent/Guardian Date

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Please Read the following and sign and date at the bottom for ALL statements

Accuracy Statement:
I certify that I have answered the preceding intake forms honestly and to the best of my knowledge. Optimal Health Chiropractic will not be liable because of any misinformation or any information that I have not disclosed to my doctor.

Terms of Acceptance:
We do not offer to diagnose or treat any Disease. We diagnose vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you toward the appropriate referral. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you follow this referral. Our practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body with adjustments.

HIPAA Notification:
Under HIPAA, health information may be used only for treatment, payment or health care operations unless the patient gives written permission or federal law specifically allows the use. Apart from treatment activities, providers must use only the "minimum necessary" information to accomplish the intended purpose.

By signing below I acknowledge that I read understand and agree with the above three statements.

Name (printed) Signature Date