ELBERT FAMILY Chiropractic

PEDIATRIC CHIROPRACTIC INTAKE FORM

Dr. Mason Elbert, D.C | Chiropractor
607 2nd Street . Jackson, MN . 56143

Patient (Child) Information:

Name: _____ Date: ____/____/_____

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

Sex: Male Female Date of Birth: ____/____/_____ Height: _____ Weight: _____

If under 12 months: Weight at birth: _____ Length/ Height at birth: _____

Gestational Age at Time of Birth: _____ Weeks

Name of Parents/Guardian: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Present Complaint:

Reason for visit: _____

When did this begin? _____

Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N

If yes, describe: _____

Current medications: _____

General Questions/Prenatal History:

Any complications during pregnancy? Y N

If yes, explain: _____

Duration of Labor: _____ Time Spent Pushing: _____

Cigarettes or alcohol during pregnancy: Y N

Birth Intervention: Forceps Vacuum C-Section Complications during delivery? Y N

If yes, explain: _____

Genetic disorders or disabilities? Y N If yes, explain: _____

Has your child received vaccinations? Y N

Date of last visit to Primary Care Physician: ____ / ____ / _____

Feeding History: (If under 24 months)

Breast Fed: Y N How long: _____
Formula Fed: Y N How long: _____
Food allergies or intolerances? Y N
If yes, please list: _____

Please list any childhood diseases and age of child when contracted:

_____

Developmental History: (If under 3 years)

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

Is/has your child been involved in any high impact or contact type of sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N

Has your child ever been involved in a car accident? Y N If yes, explain: _____

Other traumas not described above? Y N If yes, explain: _____

Prior surgeries? Y N If yes, explain: _____

Review of Systems Please check if your child has had any of the following:

____ Headaches	____ Postural Imbalances	____ Growing Pains	____ Scoliosis
____ Tonsillits	____ Asthma	____ Torticollis	____ Ear Infections
____ Seizures	____ Sleep Problems	____ Digestive Problems	____ Bedwetting
____ PDD/Autism	____ ADD/ADHD	____ Frequent Fever	____ Colic
____Learning Difficulties	____ Acid Reflux	____ Hip Dysplasia	____ Allergies

Authorization to Treat a Minor

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I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request Dr. Mason Elbert to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Parent/Legal Guardian Name: _____ _____

Parent/Legal Guardian Signature: _____

Date: ____ /____ /_____