Barbara Schellenberg, DC
1650 45th St S. Ste 204
Fargo, ND 58103

One Light Chiropractic

Pediatric
Intake Form
701.306.0714

PATIENT INFORMATION

Name:_____ DOB: _____/_____/_____ Age:_____ Sex M F

Address:_____ City:_____ Zip:_____

Email: _____ Home: ( )_____ Cell: ( )_____

Names of Parents/Guardians: _____

How did you hear about Dr. Barb? ❍ Internet ❍ Referral/word of mouth ❍ Other_____

PATIENT HEALTH HISTORY:

Reason for today's visit? _____

_____

_____

Other Health professionals seen for this condition? Y N

If yes, please tell me name of practitioner, prior treatment and outcome of treatment, if any.

1._____

2._____

3._____

4._____

Please check off any of the following symptoms your child has experienced?

___Ear infections
___Colic
___Spitting up as infant/vomiting
___Difficulty sucking or nursing

___Frequent illness (cold, flu)
___Bed wetting
___Seizures
___Temper tantrums/poor behavior

___Headaches
___Difficulty breathing/Asthma
___Poor concentration
___Autism spectrum disorder

___Pain
___Car accident
___Scoliosis
___Other:_____

Food/Air intolerances or allergies? Y N If yes, Please list:_____

_____

_____

Please list ALL medications and/or nutritional supplements your child is currently taking?

1._____ Dosage:_____ How long taking?_____ Reason?_____

2._____ Dosage:_____ How long taking?_____ Reason?_____

3._____ Dosage:_____ How long taking?_____ Reason?_____

4._____ Dosage:_____ How long taking?_____ Reason?_____

Would you be interested in learning more on how you can ensure your child has adequate nutrition? Y N

Please list ALL medications (including antibiotics) your child has taken in his/her lifetime? And reason for taking?

_____

_____

Would you like information on how to ensure proper nutrition for your child? Y N

Has your child ever been on probiotics? Y N Is he/she currently taken them? Y N

Has your child ever been vaccinated? Y N Are you following the recommended schedule? Y N

Would you like information on the potential risks of vaccination? Y N

Childhood Diseases:

Chicken Pox	Y N	Age_____	Mumps	Y N	Age_____
Rubella	Y N	Age_____	Whooping Cough	Y N	Age_____
Rubeola	Y N	Age_____	Other	Y N	Age_____

Prior Surgery? Y N If yes: Date_____ Type:_____ Reason:_____

Has your child ever been treated on an emergency basis? Y N

If yes, please describe:_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, stairs, etc.). **Was this the case with your child?** _____Y _____N

Describe:_____

Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, cheerleading, etc.)?

_____Y _____N List:_____

Other traumas not mentioned? Y N Describe:_____

Previous Chiropractor? Y N Name of DC: _____

Approx. Date of last visit? _____ Reason: _____

Name of Pediatrician:_____ Date of last visit?_____

Name of office:_____ Phone:_____

DEVELOPMENTAL HISTORY:

Did your child ever crawl? Y N Did they crawl with the cross-crawl/normal position? Y N

If not the cross-crawl, then please describe:_____

When did they start to crawl? _____ Stand?_____ Walk on own?_____

How would you describe your child as an infant?

___very relaxed ___comfortable ___agitated/tense

___sleeps too much ___sleeps just right ___never seems to sleep well

PRENATAL HISTORY:

Name of Obstetrician/Midwife:_____

Location of Birth: ___Hospital ___Birthing Center ___Home

Complications during pregnancy? Y N If so, please describe:_____

_____

Did you have any ultrasounds during pregnancy? Y N How many?_____

Medications during pregnancy/delivery? Y N Please List:_____

Cigarette/Alcohol use during pregnancy? Y N Back pain? Y N Rib pain? Y N Groin pain? Y N

Birth intervention: ___Forceps ___Suction ___C-Section ___Abnormal pulling

Complications during delivery? Y N Please List:_____

Duration of pregnancy? _____weeks Were you induced? Y N Bed Rest? Y N How long?_____

FEEDING HISTORY:

Breast Fed? Y N If yes, how long? _____ Complications with nursing? Y N He/she favor a side? Y N

Formula Fed? Y N If yes, how long?_____ Brand & Type:_____

Introduced to solids at: _____months Cow's milk?_____

Did your child have any problem with any formulas or food? Y N

If yes, please describe:_____

AUTHORIZATION FOR CARE OF MINOR CHILD

I hereby authorize Dr. Barbara Schellenberg to administer care to my son/daughter as she deems necessary within the scope of her chiropractic practice. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name:_____ Date:_____

Relationship to child:_____