

Appalachian Family Chiropractic

643 Greenway Road, Suite J3

Boone, NC 28607

828.355.9052

Pediatric Intake Form

Child's Name _____ Parent's Name _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Alternate phone _____

Birthdate _____ Birth weight _____ Current weight _____

Sex _____ # of Siblings _____ Birth length _____ Current length _____

Type of birth: _____ Normal Vaginal _____ Forceps _____ Breech _____ Cesarean

_____ Home _____ Birthing Center _____ Hospital

List any problems during pregnancy: _____

List any problems during labor/delivery: _____

Was there presence at birth of: _____ Jaundice (yellow) _____ Cyanosis (blue) Apgar Scores _____

Congenital Anomalies/Defects _____

Infant feeding: _____ Breast _____ Bottle _____ Formula

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

Obstetrician/Midwife _____

Name

Location

Pediatrician/Family MD _____

Name

Location

Date of last visit to MD _____ Purpose _____

Immunization History: _____

Purpose of this appointment: _____

Has your child ever been treated on an emergency basis? _____ If so, describe: _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this clinic and it's Doctor (s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Signed: _____ Date: _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Signed: _____ Date: _____