

Arise Chiropractic Wellness Center, LLC
Dr. Lisa M. Hinkle
605 N. Bentz Street, Suite 103 * Frederick, MD 21701
Phone (301) 662-4220 * Fax (301) 662-8195

PEDIATRIC INTAKE FORM

Personal Information

Full Name: _____ Today's date: _____

Preferred Name: _____ Age: _____ Date of Birth: _____

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

Parents' Names: _____ Contact Phone: _____

Pediatrician: _____ Phone: _____

Siblings Names: _____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____

Who may we thank for referring you to our office?

Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out this form on their own.

Is this visit the result of (please circle): auto injury wellness care other _____

What is/are the health condition(s) you are concerned with today?

*Major concern? _____

*Onset? _____

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine.

Have you had this or similar conditions in the past? _____

Have you been treated by a medical doctor for this condition? _____

If so, where? _____ Results? _____

Have you ever had Chiropractic Care before? _____

If so, whom? _____ Results? _____

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Patient Name: _____

Date: _____

Wellness Profile:

Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Circle as many goals as you wish.

- | | | |
|-------------------------------|-------------------------------|------------------------|
| more energy | better sleep | freedom from pain |
| easier breathing | more balanced posture | improve nutrition |
| improved coordination | reduce medications | improve overall health |
| better sports performance | enhanced emotional well-being | better concentration |
| greater resistance to disease | other _____ | |

Health History:

Please explain any difficulties during pregnancy or labor: _____

The following occurred at delivery (please circle all that apply):

- | | | |
|-------------------|---------------------|---------------------|
| Anesthesia Used | Breech Presentation | Emergency C-Section |
| Face Presentation | Forceps/Vacuum | Induced labor |
| Planned C-Section | Vaginal Delivery | Intensive care |

During Infancy my child was: Breast Fed _____ months Bottle Fed _____ months

My child is on the following vaccine schedule (please circle): standard alternative none

PERSONAL HEALTH HISTORY - Has this child ever suffered from:

- | | | |
|--------------------------------|----------------------|----------------------|
| Major falls/injuries/fractures | Respiratory problems | Ear Infection |
| Allergy/Asthma | Bedwetting | Digestive problems |
| Medication: _____ | Hyperactivity | Hospitalization |
| Anxiety Disorders | Seizures | Extremity/ back pain |
| Gait problems | Antibiotic use | Behavioral problems |
| Dizziness/Fainting | Heart trouble | Diabetes |
| Anemia/Blood Disorders | Tuberculosis | High blood pressure |
| Arthritis | Headaches | Growing Pains |
| Colic | Sinus trouble | Poor appetite |

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Patient Name: _____

Date: _____

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s): _____

Allergies to foods or medications: _____

Surgeries: _____

Past Serious Accidents: _____

Please answer the following as completely as possible. Does your child:

Take supplements or vitamins? _____

Follow a special diet? _____

Carry a backpack (what style)? _____

Play Sports (which one(s))? _____

Watch TV (amount/day)? _____

Play Computer/Video Games (amt/day)? _____

FAMILY HEALTH HISTORY - Please circle the conditions below if someone in the child's immediate family has had the following. Please write how they are related to the child.

Back Problems _____	Headaches _____
High blood pressure _____	Ulcer/Digestive Problem _____
Thyroid Disorder _____	Heart Disease _____
Stroke _____	Arthritis _____
Diabetes _____	Cancer _____
Osteoporosis _____	Mental Illness _____

Consent to Treat a Minor

I hereby authorize Arise Chiropractic Wellness Center, LLC and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Legal Guardian

Date

Witness

Date