FORTITUDE FAMILY CHIROPRACTIC
Pediatric Intake Form

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ DOB: _____-_____-_____ Age: _____ ◯ Male ◯ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Mother's Name: _____ DOB: _____-_____-_____ SS#: ____-_____-_____

Mother's Phone: Cell: _____ Work: _____ Home: _____

Father's Name: _____ DOB: _____-_____-_____ SS#: ____-_____-_____

Father's Phone: Cell: _____ Work: _____ Home: _____

Pediatrician/ Family MD: _____ Name of Practice: _____

Last Visit Date: ____-_____-_____ Reason for visit: _____

Who may we thank for referring you? _____

List the Health Concerns That Brings Your Child into Our Office

Purpose of this Visit: ( ) Wellness Check-up ( ) Active Health Concern ( ) Injury or Auto- Accident

Health Concerns (List according to severity)	Rate of Severity (0= no pain, 10=unbearable)	When did this problem begin?	Have you had the problem before? When?	Are symptoms constant (C) or intermittent (I)?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Have you seen other doctors for these conditions? YES / NO

Chiropractor? _____ Medical Doctor? _____ Other _____

Results of treatment? _____

Labor + Delivery History

Child's birth was: (Circle One) Natural Vaginal Birth Scheduled C-Section Emergency C-Section

Location of birth: (Circle One) Home Birth Center Hospital Other: _____

At how many weeks was your child born? _____ Induced? Yes/ No Explain: _____

Was Birth Intervention used? (Circle One) Forceps Vacuum Extraction Induction C-Section

Medications used during delivery?: _____

Growth + Development

Breast Fed: Yes/ No How Long? _____ Formula Fed: Yes/ No How Long?_____

Difficulty breastfeeding Yes/ No Introduced solid foods at ____ months

Did/ does your child suffer from colic, reflux, or constipation as an infant? Yes or No

If yes, please explain: _____

Have you chosen to vaccinate your child? (Circle One) No Yes, on a delayed schedule Yes, on schedule

If yes, please list any vaccine reactions: _____

Food Allergies/ Intolerances and when they began: _____

Has your child received any antibiotics? Yes or No If yes, for what and how often? _____

Present prescription drugs/ dosages: _____

Over the counter Drugs (Tylenol, cough syrup, laxatives, etc.) _____

List all hospitalizations and surgeries, including the year: _____

List all major accidents, falls, head injuries, or fractured bones your child has had, including the year:

_____

Night terrors or difficulty sleeping? Yes or No If yes, explain: _____

Behavioral, social, or emotional issues? Yes or No If yes, explain: _____

At what age did your child: Respond to sound: _____ Follow an Object: _____ Hold their head up: _____

Vocalize: _____ Teethe: _____ Sit alone: _____ Crawl: _____ Walk: _____

Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Activities of Life (Ages 0-2 years)

Please identify how your child's current condition is affecting his/her ability to carry out activities that are routinely part of their life:

ACTIVITIES:	EFFECT:			
Holding Head Up	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Tummy Time	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Nursing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sitting Up	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Crawling	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Standing Alone	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Walking Alone	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Being changed	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sleep	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform

LIST RESTRICTED ACTIVITY	CURRENT ACTVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____

Activities of Life (Ages 3-12 years)

Please identify how your child's current condition is affecting his/her ability to carry out activities that are routinely part of their life:

ACTIVITIES:	EFFECT:			
Stand	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sit	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Walk	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Run	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Exercise/ Play	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Chores	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Play Sports	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Read	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sleep	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform

LIST RESTRICTED ACTIVITY	CURRENT ACTVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your Top 3 Health Goals for your child:

1. _____
2. _____
3. _____

X-RAYS AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Fortitude Family Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Guardian Signature: _____ Date: _____

Written Consent for a Child

Name of practice member who is a minor/child: _____

I authorize Dr. Matthew Rauco and all Fortitude Family Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Fortitude Family Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to Minor / Child: _____

Doctor Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

We love to have pictures in our office!

If you would allow us to have your picture in the office, please sign below

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Fortitude Family Chiropractic, or anyone authorized by Fortitude Family Chiropractic, of any and all photographs/videos which were taken of myself and/or my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Fortitude Family Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regard to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Fortitude Family Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.