Lakeside Family Chiropractic
Dr. Scott McGregor D.C.

Welcome to our office!
Pediatric Intake Form

Date: _____ PLEASE PRINT – THANK YOU

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address: _____

City / Prov / PC : _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Birth Date: _____ Age: _____ Sex: ◯M ◯F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

# of Children: ◯ ◯ ◯ ◯ Children's Names & Ages: _____

_____

Who can we thank for referring you or how did you hear about our office? _____

_____

Do you have an extended health insurance plan through your place of work? (Benefits) ❑ Y ❑ N

If yes, Name of Insurance Company _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Lakeside Family Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries, (auto accidents, falls, concussions) and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? ◯Yes ◯ No If yes, were X-Rays taken? ◯ Yes ◯ No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

Print Patient's Name: _____ Date: _____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Frequent Sickness
- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic Bronchitis
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain/Stiffness
- ☐ Difficulty Gaining Weight
- ☐ Ear or Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

_____

_____

_____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____

_____

_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Antibiotics
- ☐ Migraine/Headache
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Digestive
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

_____

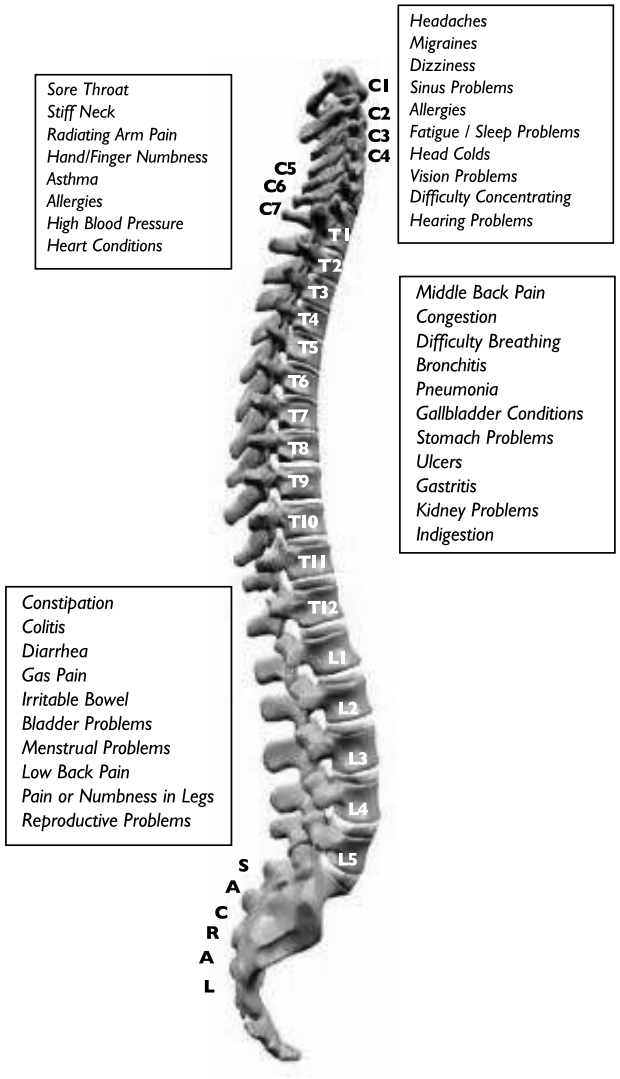
_____

_____

_____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

_____

_____

Print Patient's Name: _____ Date: _____

PRENATAL HISTORY

Location of birth: ◯ Home ◯ Birthing Center ◯ Hospital ◯ Other: _____

Did any of the following happen during delivery:

C-section delivery - Doctor pulled or twisted baby - Anesthesia - Labor was induced

Forceps/vacuum extraction - Premature delivery - Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:

_____

Did you experience any illness while pregnant? Yes No If yes, explain: _____

Do you have any physical disabilities? ◯ Yes ◯ No If yes, explain: _____

Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____

Ultrasound used during pregnancy? ◯ Yes ◯ No Number of times: _____

Did you breastfeed the baby? Yes ◯ No ◯ If yes, how long: _____

Did you formula-feed the baby? Yes ◯ No ◯ If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child exercise daily? Yes ◯ No ◯ How much? _____

Does your child drink soda? Yes ◯ No ◯ How much/often? _____

Does your child have a positive self-esteem or self-image? ◯ Yes ◯ No

Does your child watch more than an hour of TV per day? ◯ Yes ◯ No How much? _____

Does your child eat balanced meals? ◯ Yes ◯ No

Does your child experience prolonged sadness? Yes ◯ No ◯ Explain: _____

Does your child have difficulty sleeping? Yes ◯ No ◯ Explain? _____

Does your child play video games? Yes ◯ No ◯ How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes ◯ No ◯ Explain: _____

Has your child ever been hospitalized or had surgery? Yes ◯ No ◯ Explain: _____

Does your child have difficulty interacting with others? Yes ◯ No ◯ Explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes ◯ No ◯ Explain:

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes ◯ No ◯

Please list: _____

Are you aware of any food allergies or intolerance? Yes ◯ No ◯ Explain: _____

Has your child received all recommended vaccinations? Yes ◯ No ◯ Explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 Personal: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

PERMISSION TO CARE FOR A MINOR

I, (parent/guardian) _____, give Lakeside Chiropractic permission to examine, x-ray (if necessary), and treat _____.

Minor date of birth: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

Print Patient's Name: _____ Date: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- In the event we can help you, we urge our patients to follow the doctor's recommentations for care. Payment is due upon services rendered. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- *A $25 fee will be charged to your account for any appointments missed without a 24 hour notice of cancellation. We require a credit or debit card on file due to this policy.*
- I authorize Lakeside Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Patient Signature: _____ Date: _____

CONSENT TO/TERMS OF ACCEPTANCE

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic care in general, (including spinal adjustment), the care options are recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic care recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my person and future chiropractic care.

Dated this _____ day of_____, 20_____.

Patient Signature (Legal Guardian) Witness of Signature

_____ _____

Name: _____ Name: _____

(please print) (please print)

SAVE PRINT Submit Form RESET