Junge Family CHIROPRACTIC, LLC

New Patient Intake Form

Patient Name_____Date_____

Name of Parent or guardian_____

Address_____City_____State_____Zip____

HomePhone(____)_____CellPhone(_____)_____WorkPhone(____)_____

Email_____

Birth Date_____Age_____ Number of Brothers_____ Sisters_____

Height_____ Weight_____ Sex _____

How did you hear about us_____ Referred by_____

Patient History

List any chiropractors you have seen before?

Name_____City_____State_____When_____
Name_____City_____State_____When_____

Have you ever been to a Gonstead Chiropractor? ☐ Yes ☐ No

List medical doctors you have seen within the last year:

Name_____City_____State_____When_____
Name_____City_____State_____When_____

List all accidents or injuries:

Type_____When_____
Type_____When_____

List all Surgeries:

Type_____When_____
Type_____When_____

List medications and/or vitamins and supplements you are taking:

Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____

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Pediatric Intake Form

Patient Name_____Date_____

Birth and Care History

Birth Weight_____ Birth Length_____

Delivery: □ Normal □ Vaginal □ Forceps □ Breech □Cesarean □Home □Birthing Center □Hospital

Problems during pregnancy, labor or delivery: _____

Infant Feeding: □ Breast □ Bottle □ Formula

APGAR Score _____ Was there presence at birth of: □ Jaundice (Yellow) □Cyanosis (Blue)

Congenital Anomalies/Defects _____

Hours sleeping per night _____ Quality of sleep: Good_____ Fair_____ Poor_____

Date of Last visit to MD _____ Purpose _____

Immunization History _____

Has your child ever been treated on an emergency basis? (Describe) _____

Number or doses of Antibiotics your child has taken:

During past 6 months _____ During his/her lifetime_____

Present History Purpose of this appointment

_____

_____

_____

Please note any other special information

_____

_____

Pediatric Diet and Conditions History

At what age were solids introduced?_____ Which food(s) were given first?_____

Does your child consume milk? _____if yes, how many glasses a day? _____

Dairy (cheese, yogurt, etc)_____ if yes, how much in a day? _____

Does your child have any food allergies? If so, to what?_____

Does your child drink water throughout the day? _____ if yes, how many glasses?_____

Juice_____ Soda_____

Has your child ever suffered from? (Check all that apply)

[ ] Headaches	[ ] Orthopedic Problems	[ ] Digestive Disorders	[ ] Behavioral Problems
[ ] Dizziness	[ ] Neck Problems	[ ] Poor Appetite	[ ] ADD/ADHD
[ ] Fainting	[ ] Arm Problems	[ ] Stomach Aches	[ ] Ruptures/Hernia
[ ] Leg Problems	[ ] Reflux	[ ] Muscle Pain	[ ] Heart Trouble
[ ] Constipation	[ ] Growing Pains	[ ] Back Pain	[ ] Seizures/Convulsions
[ ] Ear Infections	[ ] Diarrhea	[ ] Joint Problems	[ ] Allergies_____
[ ] Sinus Trouble	[ ] Poor Posture	[ ] Diabetes	[ ] Allergies_____
[ ] Asthma	[ ] Scoliosis	[ ] Hypertension	[ ] Allergies_____
[ ] Colds/Flu	[ ] Walking Trouble	[ ] Anemia	[ ] Other_____
[ ] Colic	[ ] Broken Bones	[ ] Bedwetting	[ ] Other_____

Has the child ever suffered the following spinal traumas? (Check all that apply.)

[ ] Fall in baby walker	[ ] Fall from bed or couch	[ ] Fall off skateboard	[ ] Fall off skates
[ ] Fall off swing	[ ] Fall from crib	[ ] Fall from highchair	[ ] Fall off bicycle
[ ] Fall down stairs	[ ] Fall from counter	[ ] Fall off monkey bars	[ ] Fall off slide
	Other : [ ] _____	[ ] _____	[ ] _____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____ Other_____