Welcome to McGovern Chiropractic

Pediatric Intake Form

Please complete fully so we can help your child best.

Child's Legal Name:	Today's Date: _____/_____/_____
What he/she prefers to be called:	
Address:	City/State/ZIP:
Home Phone:	Parent's Cell Phone:
Birth date: _____/_____/_____ Age:	
Current School:	
Mother's Name:	Father's Name:
Siblings Names and Ages:	
Who may we thank for referring your child?	
Favorite Hobbies or Interests:	

Please select any of the applicable reasons for your pursuing chiropractic care for your child:

___ He/she is continuing care from another chiropractor.
___ I'm concerned about his/her health and am looking for answers.
___ He/she has a specific condition that concerns me.
If so, please explain:

_____

_____

Is this visit the result of an auto injury? _____. If so, when was it? _____

Other doctors he/she has seen for this problem: _____

Has he/she ever been diagnosed with cancer? _____ If so, what kind? _____

Surgeries your child has had: _____

Known Allergies: _____

List any current medications: _____

List any past medications: _____

In order to better understand your child's current level of health, please check any of the following body signals that your child has had or has previously had:

___ Headaches	___ Postural Imbalances	___ Growing Pains	___ Scoliosis
___ Asthma	___ Allergies	___ Ear Infections	___ Seizures
___ Digestive Problems	___ Bedwetting	___ PDD/Autism	___ ADD/ADHD

Other: _____

Prenatal History:

Adopted? _____

Complications during pregnancy? _____. If so, please explain: _____

Ultrasounds during pregnancy? _____. If so, how many? _____

Medications/drugs/caffeine during pregnancy? _____. If so, please list type and amount: _____

_____

Cigarette/Alcohol use during pregnancy? _____. If so, please list type and amount: _____

_____

Location of birth: ____Hospital _____Birthing Center ____Home

Birth Intervention: ____ Mother Induced ____ Mother Medicated (Pitocin, etc.)

____ Forceps ____ Vacuum Extracted

____ Baby given Medication after delivery; List: _____

Complications during delivery? _____. If so, please explain: _____

Genetic Disorders/Disabilities? _____. If so, please explain: _____

Breast Fed? _Y or N How long?_____ Formula Fed? __Y or N _ How long? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child?_____. Please explain: _____

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? _____. If so, please list: _____

_____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

McGovern Chiropractic
85 Constitution Lane, Suite #1E, Danvers, MA 01923

Patient Name: _____ Date: _____

Below is a list of health issues that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING HEALTH ISSUES YOU HAVE <u>EVER</u> HAD:

□ Pneumonia	□ Mumps	□ Influenza
□ Rheumatic Fever	□ Smallpox	□ Pleurisy
□ Polio	□ Chicken Pox	□ Arthritis
□ Tuberculosis	□ Diabetes	□ Epilepsy
□ Whooping Cough	□ Cancer	□ Mental Disorders
□ Anemia	□ Heart Disease	□ Thyroid Imbalance
□ Measles	□ Heart Attack	□ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST YEAR:

NERVOUS SYSTEM CODE
□ Nervousness/anxiety
□ Irritability/impatience
□ Depression
□ Attention deficit
□ Stress
□ Dizziness
□ Forgetfulness
□ Confusion
□ Fainting
□ Convulsions
□ Cold Extremities

GENERAL
□ Headaches
□ Migraines
□ Loss of Sleep
□ Allergies
□ Fatigue
□ Fibromyalgia

GENITO-URINARY
□ Bladder Trouble
□ Discolored Urine
□ Painful Urination
□ Excessive Urination

EENT
□ Vision Problems
□ Sinus Infections
□ Earaches
□ Hearing Difficulty
□ Tinnitus

GASTROINTESTINAL
□ Poor Appetite
□ Excessive Appetite
□ Excessive Thirst
□ Excess Weight
□ Significant Weight Loss
□ Frequent Nausea
□ Gas or Bloating After Meals
□ Heartburn
□ Vomiting
□ Diarrhea
□ Constipation
□ Abdominal Cramps
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Diagnosed IBS, Crohn's, Diverticulitis, Colitis
□ Black/Bloody Stool

CARDIOVASCULAR/RESPIRATORY
□ Chest Pain
□ Asthma
□ High Blood Pressure
□ Irregular Heartbeat
□ Stroke
□ High Cholesterol

MALE/FEMALE
□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/Infection
□ Breast Pain/Lumps
□ Prostate Dysfunction
□ Infertility Problems
□ Other: _____
_____

FAMILY HISTORY
The following family members have the same or similar problem(s) as I do:
□ Mother
□ Father
□ Sister
□ Brother
□ Spouse
□ Child