Pediatric Intake Form

Please fill out as thoroughly as possible and bring to your first visit.

PATIENT INFORMATION

Name____ **DOB**______________ **Age**: ________ **Years** _________ **Months**

By what name would she/he liked to be called? _________________________ **Sex:** ☐ Male ☐ Female

Mother's Name:___________________________________ **Email**____

Occupation_______________________ **Employer**________________________________ **Hours /wk worked?**_______

Telephone: Home______________________ **Cell** ___________________________**Work**__________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Father/Partner's Name:_______________________________ **Email**____

Occupation_______________________ **Employer**________________________________ **Hours /wk worked?**_______

Telephone: Home_____________________ **Cell** ___________________________**Work**__________________________

Child's Home Address____ **City/Zip**____________________________

Would you like to receive a reminder email before your appointments? ☐ Yes ☐ No

At what numbers may we leave health-related messages? ☐ Home ☐ Cell ☐ Work

Emergency contact_______________________ Relation____________________ Telephone_________________________

Please send announcements, lecture schedules and newsletters via: ☐ Email ☐ Regular Mail ☐ Neither

Ethnicity: ☐ Caucasian ☐ Hispanic/Latino ☐ African American ☐ Asian or Pacific Islander
☐ Multiracial ☐ Native American ☐ Unknown ☐ Decline Response ☐ Other:___________________

How were you referred to care? ☐ Friend ☐ Physician ☐ Colleague ☐ Relative ☐ Website ☐ Social Media ☐ Other___________________

Referring person's name: ____

Child's Primary care Physician: _____________________________________ **Phone:**____________________________

Insurance Carrier: ____

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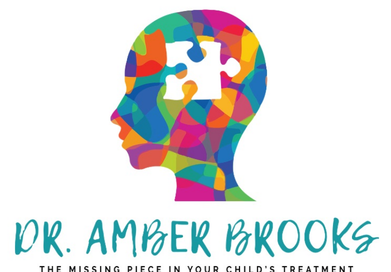

CURRENT HEALTH CONCERNS

Please list current concerns in order of priority:

Condition or Concern (in order of importance)	Onset	Diagnosed by physician?
		Yes No
		Yes No
		Yes No
		Yes No

1. Primary reason for seeking Chiropractic / Integrative Care:

Primary Reason:____

Secondary Reason:____

Other factors contributing to the primary and secondary reasons: ___________________________

2. Chief Complaint: ____

Location of Complaint: ____

Complaint began when and how? ____

How frequent is complaint present, how long does it last? ___________________________

Does anything aggravate the complaint?____

Does anything make the complaint better? ____

Previous interventions, treatments, medications, surgery, or care you have sought for your complaint?

____

Previous injury or trauma: ____

Previous Motor vehicle accidents: ____

Have you seen a chiropractic doctor before? ☐ Yes ☐ No If yes, who? ___________________

CHILD'S SCHOOL PLACEMENT

Name of school: ____ **City**: __________________________________

Please describe your child's school placement:

☐ Mainstreamed with an aide ☐ Mainstreamed without an aide ☐ Self-contained special education

☐ Home schooled ☐ Daycare ☐ Reverse mainstream special education

☐ Typical preschool ☐ Resource classes as needed ☐ Not yet in school

PRENATAL HISTORY

Indicate any of the following complications that occurred during your pregnancy *with this child*.

☐ Took longer than 6 months to conceive this pregnancy
☐ Pregnancy achieved through fertility drugs and/or artificial insemination
☐ Abnormal maternal serum alpha fetal protein (MSAFP) blood test in second trimester
☐ Alcohol use: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
☐ 1 drink per day ☐ Greater than 1drink per day
☐ Amniocentesis at ______ weeks
☐ Asthma
☐ Beta Strep vaginal colonization (typically asymptomatic in mother, but treated during labor)
☐ Bleeding ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester
☐ Chemical or toxic exposure:
☐ Anesthetic gases/anesthesia ☐ Dental amalgams placed or repaired during pregnancy ☐ Indoor pesticides ☐ Lead
☐ New carpeting ☐ New paint ☐ Outdoor pesticides ☐ Other _______________

☐ Cigarette smoking:
☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
☐ ½ pack per day or less ☐ greater than ½ pack per day

☐ Diabetes
☐ Gestational Diabetes
☐ High blood pressure: ☐ Chronic hypertension ☐ Pregnancy induced hypertension
☐ Hypothyroidism (underactive thyroid)
☐ Infection or illness:
☐ Cytomegalovirus (CMV) ☐ Mononucleosis (Epstein Barr virus) ☐ Bladder infection
☐ Pyelonephritis (kidney infection) ☐ Other: _______________________

☐ MTHFR Mutation
☐ Placenta Previa (low placenta)
☐ Preterm/premature labor (requiring bed rest or medical care beginning at ____________weeks Protein in urine
☐ Radiation exposure
☐ Severe nausea and/or vomiting (hyperemesis)
☐ Substance abuse:
☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Narcotics
☐ Hallucinogens ☐ Amphetamines ☐ Other ___________________________________

PRENATAL HISTORY (continued)

☐ Toxemia/preeclampsia beginning at ________________ weeks gestation
☐ Twin or triplet pregnancy
☐ Quadruplet or quintuplet pregnancy
☐ Prescription medication use: ____

☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

☐ Injury:____
☐ Vaccination within 3 months prior to conception or during pregnancy (please specify)

☐ Flu Shot ☐ DTAP ☐ Other: _____________________

☐ Vegetarian diet
☐ Other: ____
☐ No complications occurred during my pregnancy

PERINATAL & NEONATAL HISTORY

Mother's age at birth: _________ years **Father's age at time of birth**: ___________ years
Weight gained during pregnancy: ____________ pound
Number of metal (silver/mercury) fillings present during pregnancy: ___________
Number of servings tuna, swordfish, or other high mercury fish per month: _____________

Was labor induced with Pitocin?	YES	NO	Unknown
Was labor induced with Prostaglandin gel?	YES	NO	Unknown
Was labor augmented with Pitocin?	YES	NO	Unknown

This child was born by:

☐ Normal Vaginal Delivery	Total Labor Time:_________	Push Time:_____________	
☐ Forceps Vaginal delivery			
☐ Vacuum Delivery			
☐ Cesarean Delivery Due to:	☐ Large baby/failure to progress in labor ☐ Placenta previa (low placenta)	☐ Fetal distress ☐ Scheduled repeat cesarean	☐ Breech or other abnormal presentation ☐ Other:

Length of pregnancy:

☐ Premature			
☐ Full term (40 weeks)			
☐ Past due date (>40 weeks)	☐ <1 week late	☐ 1-2 weeks late	☐ >2 weeks late

PERINATAL & NEONATAL HISTORY (continued)

Born at ______________ weeks **Birth weight** ______________pounds ______________ ounces

Nursery stay?

☐ No

☐ Yes Reason:____ ☐ Length of stay:_____________

APGAR Scores:		1 Minute		5 Minutes		Unknown

Discharged from the hospital when __________ day(s)/ ___________ week(s) old

Did your child receive the Hepatitis B vaccine within the first week of life? ☐ YES ☐ NO ☐ Unknown

Mark which vaccinations your child has had and the approximate date of the vaccination. If they date is unknown just mark online or delayed

Vaccine	**Date**	**Date**	**Date**	**Ontime/ Delayed?**	**Vaccine**	**Date**	**Date**	**Date**	**Ontime/ Delayed?**
☐ Hepatitis B					☐ DTap				
☐ Polio					☐ Hepatitis A				
☐ Varicella (Chicken Pox)					☐ Rotovirus				
☐ Hib (Haemophilus Influenzae)					☐ Pneumococcal				
☐ Flu					☐ MMR (Measles, Mumps and Rubella)				

List any known food Sensitivities/allergies:

____

____

____

How many flu vaccines has your child received and at what age(s)?

____

Describe your child's attitude currently and as an infant?

____

____

____

DIAGNOSTIC INFORMATION

***Check any complications that occurred at birth or during your child's first month of life*:**

☐ Abnormal result on newborn screening test: ______________________________
☐ Anemia
☐ Birth defect (please describe): ______________________________
☐ Birth injury (eg fractured collarbone); please specify: ______________________________
☐ Breathing difficulty (required oxygen for more than 20 min)
☐ Cord around neck
☐ Difficulty nursing or drinking from a bottle
☐ Frequent or projectile vomiting
☐ Heart murmur or irregular heart rhythm
☐ Meconium-stained amniotic fluid ☐ with aspiration into lungs ☐ without aspiration
☐ Illness: ______________________________
☐ Jaundice: ☐ required phototherapy (bilirubin lights) ☐ did not require phototherapy
☐ Seizures
☐ Unable to tolerate milk-based formula
☐ Yeast infection (thrush, cradle cap, etc.) Please specify which one and at what age ______________
☐ Other: ______________________________

DIAGNOSTIC INFORMATION

Child's Diagnosis:

☐ Non-applicable (no diagnosis)
☐ Attention deficit disorder (ADD or ADHD)
☐ Asperger's syndrome
☐ Atypical autism
☐ Autism
☐ Genetic Abnormalities
☐ Landau-Kieffner syndrome
☐ MTHFR
☐ Multiplex developmental disorder
☐ Pervasive developmental disorder not otherwise specified (PDD, PDD-NOS)
☐ Rett syndrome
☐ Sensory Processing Disorder
☐ Other: ______________________________
____

Additional Diagnosis:

☐ None
☐ Bipolar Disorder (Manic Depressive Disorder
☐ Blindness/visual impairment
☐ Cerebral Palsy
☐ Chromosomal Abnormality: ______________________________
☐ Down syndrome
☐ Dyslexia
☐ Fragile X
☐ Hearing Loss
☐ Hyperlexia (advanced reading skills)
☐ Learning disability
☐ Mental retardation
☐ Mitochondrial disorder
☐ Obsessive compulsive disorder (OCD)
☐ Semantic-pragmatic language disorder
☐ Speech language delay
☐ Other: ______________________________
____

DEVELOPMENT DELAYS & NEUROLOGICAL SYMPTOMS

If your child does not have development delays or neurological symptoms, please proceed to "Therapies"

In my opinion, my child's disability is: ☐ mild ☐ moderate ☐ severe

Do you think that your child was born with a neurological impairment?
☐ Yes, my child was very different from birth
☐ No, my child seemed to develop and interact in a typical way until a certain age

At what age did you suspect your child had a disability? ______ years ______ months

Age at diagnosis? ______ years ______ months

Who made the diagnosis? (check all that apply)
☐ Developmental pediatrician Neurologist ☐ Pediatrician Psychiatrist Psychologist ☐ Other:________________

THERAPIES

Please check any therapies your child has received in the past or is currently receiving:

Therapy Type:	Currently	In the Past	Start Date:
Applied Behavioral Analysis (ABA)			
Applied Verbal Behavior (AVB)			
Auditory Training			
Chiropractic Care			
Feeding Therapy			
Speech Therapy			
Greenspan (floor time)			
Special Education classes			
Regular Education classes			
Occupational Therapy/Sensory Integ			
Physical Therapy			
CranioSacral Therapy (CST)			
Therapeutic Horseback riding			
Music Therapy			
Relationship Develop. Intervention			
Other:			

SIBLING HISTORY

Number of children in the family:

Child's birth order: ☐ 1st ☐ 2nd, 3rd, 4th ☐ 5th or higher ☐ Adopted

Other children in the family:

Name:	Age:	Sex	Developmental delays?	Place of residence
		M F	☐ None	
		M F	☐ None	
		M F	☐ None	
		M F	☐ None	

Number of miscarriages prior to pregnancy with affected child?

☐ None ☐ One ☐ Two ☐ Three or more

Was Rhogam given during pregnancy? (given for Rh negative women)

☐ Yes ☐ No ☐Unknown

DEVELOPMENTAL & HEALTH HISTORY

Check any medical illnesses that your child has currently or in the past:

☐ Adverse reaction to a vaccination ____

☐ Asthma

☐ Chronic constipation beginning at ______ months of age to age ______

☐ Chronic diarrhea beginning at ______ months of age to age ______

☐ Encephalitis or meningitis at ______ months

☐ Eczema

☐ Febrile seizures (fever-related) at ______ months

☐ Grand mal seizures (tonic clonic) Onset at _______ months/years

☐ Petit mal seizures (complex partial or simple) Onset at _______ months/years

☐ Strep throat or other Strep infection

☐ Thrush

☐ Other medical illness: ____

Is your child allergic to any medication? ☐ No ☐ Yes ______________________________

Is your child around anyone who smokes? ☐ No ☐ Yes ______________________________

Number of otitis media (inner ear) infections in the:

1st year of life	2nd year of life	3rd year of life
☐ 0-3	☐ 0-3	☐ 0-3
☐ 4-6	☐ 4-6	☐ 4-6
☐ 7 +	☐ 7+	☐ 7+

DEVELOPMENTAL & HEALTH HISTORY (continued)

At what age did your child achieve the following developmental milestones?

Coo _________ Months

Babble ('mamma', 'baba', etc) _________ Months

Speak first true word _________ Months ☐ My child has never spoken

Speak in two word phrases _________ Months ☐ Not yet using 2-word phrases

Did your child ever lose language (babbling, words and/or receptive language)?

☐ No
☐ Yes at: ☐ <15 mo. ☐ 15-18 mo. ☐ 19-24 mo. ☐ 25-30 mo. ☐ 31-36 mo. ☐ 37 mo. Or greater

Which best describes your child:

☐ Accelerated language development Normal language development
☐ Normal language development until approx. _______ months, followed by a plateau
☐ Normal language development until approx. _______ months, followed by a regression Always slow to acquire language with no obvious period of regression
☐ Always slow to acquire language and then regression in language at ______ months of age

Did your child ever lose the ability to use gestures, such as pointing or waving goodbye?

☐ No
☐ Yes at ☐ <15 mo. ☐ 15-18 mo. ☐ 19-24 mo. ☐ 25-30 mo. ☐ 31-36 mo. ☐ 37 mo. Or greater

At what age did your child learn to do the following:

Head Control:_________ Months **Sit without support:**_________ Months **Standing:**_________ Months

Roll Over (front to back):_________ Months **Crawl on hands & knees:**_________ Months **Walking:**_________ Months

Did your child ever lose gross motor skills such as walking, running, jumping or climbing?

☐ No
☐ Yes at: ☐ <15 mo. ☐ 15-18 mo. ☐ 19-24 mo. ☐ 25-30 mo. ☐ 31-36 mo. ☐ 37 mo. Or greater

Did your child ever lose fine motor skills such as drawing or doing finger movements to children's songs?

☐ No
☐ Yes at: ☐ <15 mo. ☐ 15-18 mo. ☐ 19-24 mo. ☐ 25-30 mo. ☐ 31-36 mo. ☐ 37 mo. Or greater

Did your child ever experience a regression in social skills (e.g. eye contact, ability or desire to play with peers, respond attempts at interaction)?

☐ No
Yes at: ☐ <15 mo. ☐ 15-18 mo. ☐ 19-24 mo. ☐ 25-30 mo. ☐ 31-36 mo. ☐ 37 mo. Or greater

DEVELOPMENTAL & HEALTH HISTORY (continued)

Which best describes your child?
☐ My child is not and has never been toilet trained
☐ My child is currently toilet trained, but was not toilet trained until age 3 ½ or later
☐ My child was toilet trained at one time, but regressed and now has frequent stool and/or urine accidents
☐ My child was toilet trained by 3 ½ years of age and never or rarely has accidents

List any hospitalizations, surgeries, or serious injuries that your child has had:

Hospitalized for ____ Date ____________

Surgery: ____ Date ____________

Injury: ____ Date ____________

Motor vehicle accidents: ____ Date ____________

Has your child's hearing been tested? ☐ No ☐ Yes, at _______________________ Date _______________

Has your child's vision been tested? ☐ No ☐ Yes, at _______________________ Date _______________

Do you have concerns regarding your child's vision or hearing? ☐ No ☐ Yes_______________________

NUTRITIONAL INFORMATION

My child was breastfed for: ________ months ________ non-applicable (not breastfed)

How often were/are feedings? ____

Appetite ☐ GREAT ☐ GOOD ☐ POOR

My child was bottle fed with:
☐ Non-applicable (exclusively breastfed)
☐ Milk-based formula (Enfamil, Similac, etc) from ______ to ______ months
☐ Soy-based formula (Isomil, Prosobee, etc) from ______ to ______ months
☐ Other: ____________________________ from ______ to ______ months

When did child get first teeth? _________ months _________ years

When did you introduce solid food to your child? _________ months ________ years

Did your child have colic as a newborn?
☐ No
☐ Yes, from ______ to ______ months of age

NUTRITIONAL INFORMATION (continued)

Dairy products (milk, cheese, yogurt, etc) were introduced into my childs diet at:

☐ Never introduced ☐ 0-6 months ☐ 7-12 months ☐ 12+ months

My child became a picky eater at:

☐ Non- applicable ☐ 13-15 months ☐ 19-24 months ☐ 37 months or older

☐ 12 months or younger ☐ 16-18 months ☐ 25-36 months

Check any food allergies or sensitivities that are known:

☐ Citrus fruits ☐ Gluten/wheat ☐ Other: ___________________

☐ Corn ☐ Peanuts ___________________________

☐ Dairy/casein ☐ Soy

☐ Eggs ☐ Yeast ☐ No known food allergies

Is your child on a special diet? (check all that apply and indicate date diet was initiated)

☐ No dietary restrictions ☐ Food dye free ☐ Rotational diet

☐ Casein free/dairy free ☐ Gluten free ☐ Soy free

☐ Corn free ☐ Low Oxalate Diet ☐ Vegetarian

☐ Feingold diet (salicylate free) ☐ Lutein free (Sarah's diet) ☐ Yeast free

☐ Specific carbohydrate diet (SCD) ☐ Pesticide free (organic) ☐ Other

My child regularly eats the following (check all that apply):

☐ Beans ☐ Fresh vegetable ☐ Nuts or nut butters

☐ Dairy products ☐ Gluten-free grains (bread, crackers etc) ☐ Red meat

☐ Eggs ☐ Grains containing gluten ☐ Rice or rice products

☐ Fish ☐ Potatoes ☐ Seeds (pumpkin, sunflower, etc)

☐ Fresh fruits ☐ Poultry (chicken, turkey etc) ☐ Sweets/desserts

How many ounces of the following beverages does your child drink daily?

______ Almond milk ______ Cow's milk ______ Juice

______ Water ______ Soft drinks ______ Fruit punch

______ Rice milk ______ Soy milk ______ Soda

______ Potato milk ______ Goats milk

GASTROINTESTINAL QUESTIONNAIRE

My child typically has ______ stool(s) per day/ week

Consistency is: ☐ normal ☐ watery ☐ soft or pasty ☐ loose ☐ hard

Please check any gastrointestinal symptoms your child has or has had for one month or more.

Symptom	Current only	Past only	Current & Past
Bloating or gas	________	________	________
Diarrhea (loose or watery stool)	________	________	________
Constipation (hard and/or infrequent)	________	________	________
Large volume stools	________	________	________
Abdominal pain	________	________	________
Vomiting, reflux and/or spitting up	________	________	________
Blood in stool	________	________	________
Selective appetite/picky eater	________	________	________
Excessive thirst	________	________	________
Foul smelling stools	________	________	________

Please answer the following questions if your child has any current symptoms:

Diarrhea: **How often does your child have diarrhea in an average day?**

☐ Less than 3 times per day 3-4 times per day ☐ Greater than 4 times per day

If your child currently has diarrhea, what is consistency?

☐ Soft ☐ Loose/mushy ☐ Watery

Constipation: **How many bowel movements does your child typically have per week?**

☐ Greater than 2 per week ☐ 2 per week ☐ Less than 2 per week

Is your child currently has constipation, what is consistency?

☐ Formed ☐ Hard/pebbles ☐ Hard with pain or large volume stools

Abdominal Pain: **How often does your child exhibit signs of abdominal pain?**

☐ Never or rarely ☐ 1-2 times per week ☐ Greater than 2 times per week

Vomitting/reflux: **How often does your child show evidence of this?**

☐ Never or rarely ☐ 1-2 times per week ☐ Greater than 2 times per week

MEDICATION HISTORY

Check any medications or vitamins your child has taken within the past month or anytime in the past.

Anti-fungal agents	**Current**	**Past**	**Dosage**
Diflucan			
Nizoral			
Nystatin			
Amphotericin B			
Chelating agents	**Current**	**Past**	**Dosage**
EDTA			
DMSA			
DMPS			
Psychotropics	**Current**	**Past**	**Dosage**
Adderall			
Concerta			
Dexadrine			
Ritalin			
Buspar			
Clonidine (Catapres)			
Effexor			
Geodon			
Paxil			
Prozac			
Lithium			
Wellbutrin (buproprion)			
Strattera			
Risperdal (Risperidone)			
Tenex			
Zoloft			
Zyprexa			
Other:________________			
Anti-seizure	**Current**	**Past**	**Dosage**
Depakote			
Tegretol			
Other: _______________			
Steroids	**Current**	**Past**	**Dosage**
Dexamethasone			
Prednisone			
Vitamins	**Current**	**Past**	**Dosage**
B6 or P5P			
Folapro or Methyl			
Folate (5-MTHF)			
Methylcobalamin			
(B12)injections			
Multivitamin			
Other ________________			

MEDICATION HISTORY (continued)

Supplements	Current	Past	Dosage
Acidophilus (Probiotics)			
Calcium			
DHA			
DMG (dimethylglycinez)			
EPA			
Cod liver oil/Fish oil			
Flaxseed oil			
Magnesium			
Selenium			
TMG (trimethylglycine)			
Zinc			
Fluoride (home or dentist)			
GI medications	**Current**	**Past**	**Dosage**
Digestive enzymes			
Prilosec			
Miralax			
Pentasa			
Pepcid			
N-acetyl glucosamine			
Secretin			
Zantac			
Antibiotics	**Current**	**Past**	**Dosage**
Other Medications	**Current**	**Past**	**Dosage**

If your child's health history is complicated please provide a 1-3 written summary of their challenges, assessments, interventions and therapeutic response to date. Please include any response to past treatments, whether positive or negative and indicate which intervention you have found to be most helpful.

____
____
____
____
____
____
____
____

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FAMILY MEDICAL HISTORY

Please indicate if your child or anyone in your immediate family has had any of the following conditions:
Use "D" for deceased due to this condition.
Please list extended family history and/or other conditions under "other" if relevant.

	Relationship to patient												
	Immediate Family					Mother's Side				Father's Side			
Condition	**Child**	**Mom**	**Dad**	**Bro**	**Sis**	**Aunt**	**Uncle**	**G.F.**	**G.M.**	**Aunt**	**Uncle**	**G.F**	**G.M.**
Alcoholism													
Anxiety/Panic attacks													
Asthma													
Autism/PDD NOS													
Asperger's Syndrome													
ADD/ADHD													
Alzheimer's													
Anorexia/Bulimia													
Bipolar Disorder													
Depression													
Down Syndrome													
Dyslexia													
Eczema													
High cholesterol													
Epilepsy seizures													
Gout													
Language delay													
Heart disease													
High blood pressure													
Kidney stones													
Mental retardation													
Migraines													
Night blindness													
OCD													
Parkinson's disease													
Rett's disorder													
Schizophrenia													
Spina Bifida													
Alcoholism													
Stuttering													
Stroke													
Suicide													
Tourette's Syndrome													
Tremor													
Vertigo/Meniere's													

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THE MISSING PIECE IN YOUR CHILD'S TREATMENT
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Condition	Relationship to patient												
	Immediate Family					Mother's Side				Father's Side			
	Child	**Mom**	**Dad**	**Bro**	**Sis**	**Aunt**	**Uncle**	**G.F.**	**G.M.**	**Aunt**	**Uncle**	**G.F**	**G.M.**
Gastrointestinal													
Celiac Disease													
Crohn's Disease													
Eosinophilic esophagitis													
Irritable bowel syndrome													
Pancreatitis													
Peptic ulcer disease													
Reflux (GERD)													
Ulcerative colitis													
Autoimmune													
Ankylosing													
Spondylitis													
Chronic Fatigue Syndrome													
Diabetes													
Fibromyalgia													
Lupus (SLE or discoid)													
Multiple Sclerosis													
Psoriatic Arthritis													
Rheumatoid Arthritis													
Thyroid disease													
Vitiligo													
MTHFR													
Other:													
Cancer: If anyone in your child's family has had cancer, please specify:													
Breast													
Cervical													
Colon/rectal													
Kidney													
Leukemia													
Lymphoma													
Lung													
Ovarian													
Oral (mouth, tongue)													
Pancreas													
Prostate													
Skin													
Stomach													
Uterine													
Other													

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DEVELOPMENTAL & BEHAVIORAL SURVEY

For each set of descriptions, circle or highlight the number which best describes your child **DURING THE PAST MONTH**

KEY:

1 Never **2 Rarely** **3 Occasionally** **4 Frequently** **5 Always**

	1	2	3	4	5
Communication:					
1. Able to communicate-needs verbal	1	2	3	4	5
2. Able to communicate-needs non-verbal (through signing or gestures)	1	2	3	4	5
3. Responds when name is called	1	2	3	4	5
4. Asks questions	1	2	3	4	5
5. Answers questions	1	2	3	4	5
6. Repeats words or phrases (immediate or delayed echolalia)	1	2	3	4	5
7. Able to understand simple directions ('come here', 'close door')	1	2	3	4	5
8. Makes spontaneous comments	1	2	3	4	5
Social Interaction:					
1. Concerned when seeing someone crying, sad or hurt	1	2	3	4	5
2. Looks at parent to share expressions of pleasure during fun activity	1	2	3	4	5
3. Maintains age-appropriate eye contact	1	2	3	4	5
4. Smiles in response to another person (social smile)	1	2	3	4	5
5. Responds (verbal or non-verbal) to another child's request to play	1	2	3	4	5
6. Initiates a request to play with peers (verbal or non-verbal)	1	2	3	4	5
7. References parent to obtain feedback on behavior	1	2	3	4	5
8. Enjoys new people and places	1	2	3	4	5
9. Affectionate and loving toward parents	1	2	3	4	5
10. Enjoys being held or hugged by parents	1	2	3	4	5
Behavior:					
1. Laughs or giggles without obvious reason	1	2	3	4	5
2. Exhibits repetitive or self stimulatory behavior	1	2	3	4	5
3. Flaps arms or hands	1	2	3	4	5
4. Unusual toy playing (lining up, stacking, spinning)	1	2	3	4	5
5. Disturbed by changes in routine	1	2	3	4	5
6. Eats inedible objects (dirt, sand, wood, paper)	1	2	3	4	5
7. Destructive	1	2	3	4	5
8. Aggressive (bites, hits, or harms others)	1	2	3	4	5
9. Bites hands, wrists and/or arms	1	2	3	4	5
10. Bangs or hits head	1	2	3	4	5
11. Hyperactive	1	2	3	4	5
12. Has difficulty completing activities (short attention span)	1	2	3	4	5
13. Has difficulty transitioning from one place or activity to another	1	2	3	4	5

DEVELOPMENTAL & BEHAVIORAL SURVEY

For each set of descriptions, circle or highlight the number which best describes your child **DURING THE PAST MONTH**

1 Never **2 Rarely** **3 Occasionally** **4 Frequently** **5 Always**

Sensory Issues:					
1. Bothered by certain lighting conditions (fluorescent, sunlight, camera)	1	2	3	4	5
2. Examines objects or fingers closely in front of eyes	1	2	3	4	5
3. Enjoys vestibular activities such as swinging and spinning	1	2	3	4	5
4. Places hands over ears and/or usually fearful of certain noises	1	2	3	4	5
5. Grinds teeth	1	2	3	4	5
6. Has high pain threshold	1	2	3	4	5
7. Avoids certain textures (sticky substances, etc)	1	2	3	4	5
8. Disturbed by certain items of clothing or fabric textures	1	2	3	4	5
9. Refuses foods based on texture (too chunky, smooth etc)	1	2	3	4	5
Daily Living Skills:					
14. Able to put on shirt without assistance	1	2	3	4	5
15. Able to put on pants without assistance	1	2	3	4	5
16. Combs hair	1	2	3	4	5
17. Aware of approaching danger such as cars, swings, balls, etc.	1	2	3	4	5
18. Washes hands with age-appropriate skill	1	2	3	4	5
19. Brushes teeth with age-appropriate skill	1	2	3	4	5
20. Uses a spoon or fork to eat	1	2	3	4	5
21. Urinates in the toilet	1	2	3	4	5
22. Has bowel movements in the toilet	1	2	3	4	5
Sleep:					
23. Has difficulty falling asleep	1	2	3	4	5
24. Is a light sleeper (have to creep around house so as not to wake)	1	2	3	4	5
25. Awakens in the middle of the night	1	2	3	4	5
26. Wets diaper or bed at night	1	2	3	4	5
27. Does not sleep well unless in parents bed	1	2	3	4	5
28. Does not seem to be well rested in the morning	1	2	3	4	5
Motor Skills:					
29. Walks with normal gait	1	2	3	4	5
30. Runs with normal gait	1	2	3	4	5
31. Able to jump up and down	1	2	3	4	5
32. Able to climb up stairs one step at a time	1	2	3	4	5
33. Climbs on chair to reach a desired object	1	2	3	4	5
34. Able to catch a large ball	1	2	3	4	5
35. Able to kick ball	1	2	3	4	5
36. Copies a straight line	1	2	3	4	5
37. Able to write name	1	2	3	4	5
38. Rides a tricycle or bicycle with training wheels	1	2	3	4	5
39. Has a good sense of balance	1	2	3	4	5

PARENTS PRIORITIES & EXPECTATIONS

Which of the following are health priorities in your child's care at this time (put in numerical order)?

______Decrease pain level
______Enhance cognitive function
______Improve attention span
______Increase energy level/dec. fatigue
______Improve sleep pattern
______Improve nutritional status
______Increase language
______Improve coordination
______Increase endurance
______Increase range of motion/flexibility
______Decrease anxiety level
______Decrease allergy response
______Improve diet
______Decrease sensory sensitivities
______Improve or delay exercise program
______Increase social interaction
______Increase eye contact
______Overcome asymmetric crawling patterns
______Decrease ear infections
______Decrease effects from difficult birth
______Increase weight
______Improve balance
______Improve concentration
______Minimize need for medication
______Balance/optimize hormone levels
______Improve memory
______Reduce frequency of headaches
______Reduce risk of cardiovascular disease
______Reduce risks of diabetes
______Minimize tantrums or mood swings
______Overcome depression
______Reduce bed wetting
______Decrease obsessive compulsive tendencies
______Decrease colic symptoms
______Decrease self-stimulatory behaviors
______Optimize health prior to surgery
______Initiate detoxification program
______Decrease self-injurious behaviors
______Decrease reflux
______Improve immune system
______Increase bowel movements
Other:________________________________

How do you expect to determine your satisfaction with your program?

☐ Results in 3 months ☐ Results in 6 months ☐ Results in 1 year
☐ Other (please specify): ____

STATEMENT OF FINANCIAL RESPONSIBILITY & NOTICE OF PRIVACY PRACTICES

Payment Policy

I understand that payment is expected in full at time of service and that accepted forms of payment include cash, credit card and personal checks. I am aware that NSF checks will be subjected to a $25 fee. I understand that Dr. Amber Brooks is not in network with insurance plans, the business does not guarantee reimbursement by my insurance company, and I understand that I am responsible for any deductible, co-pay, coinsurance, labs, and/or procedures not covered by my insurance. I understand that I may request the fees for various procedures before they occur in order to include that information in my healthcare decision-making process. Whole Child Wellness Center will furnish a receipt and/or HCFA insurance form that you can mail directly to your insurance company for reimbursement. I understand that my practitioner may offer telephone consultations at an additional fee, which I will be made aware of in advance.

Cancellation Policy

I am aware that Dr. Amber Brooks requires at least 24 hours notice of cancellation in advance of the scheduled appointment time.

I understand that missed appointments will be charged the full anticipated visit fee.

Late Arrival Policy

Please notify our office as soon as possible if running late for an appointment. Any time missed cannot be "made up" and you will be charged for the entire visit you were booked for plus any additional time used. As a courtesy to staff and other patients, please make every attempt to arrive on time or slightly early for your appointment.

Notice of Privacy Practices

I have read all five sections of Dr. Amber Brooks' *Notice of Privacy Practices* and understand my rights with respect to my protected health information. I understand that, upon request, I have the right to obtain a paper copy of the *Notice of Privacy Practices*.

WCW Privacy Policy

WCW requests you do not share any specific details (dosing, types of supplements, lab results, etc) of your treatment plan with anyone other than your healthcare providers, this is to ensure privacy but also in cases where parents pick up information via the internet, meetings, parent blogs, etc. The treatment plan is being supplied to your child specifically and others may have serious medical complications as a result of the same treatment, a physician should supervise any treatment. WCW cannot be liable for medical treatment or advice being given second-hand and would appreciate your assistance in ensuring our liability. If you feel someone can benefit from care with us we ask that you please refer him or her. Thank you for your consideration and cooperation.

I have read the above information and verify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Amber Brooks to provide me with Chiropractic/Integrative care, in accordance with this state's statutes.

Patient's name ____

Parent/Guardian signature____ **Date**_________________