DR. MARGIE SMITH CHIROPRACTOR

***Welcome to my practice! I appreciate your trust in me and look forward to help support your health goals for your child. Please complete the following information so I can get to know more about your child. ~Dr. Margie***

**CHIROPRACTIC INITIAL INTAKE - PEDIATRIC** DATE:_____

Child's Full Name: _____ Nickname: _____
Birthday: _____ Age: _____ Sex: Male Female
Number of Siblings: _____ Names/Ages: _____
Mother's Name: _____ Father's Name: _____
Mother or Father's Email Address: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell Phone: _____
Name of Pediatrician/Family Dr.: _____
Date of last visit to MD: _____ Reason: _____
Who may we thank for your referral today? _____
Has your child ever been to a chiropractor before? _____

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Current: Weight_____ Height_____
Any daily medications? _____
Immunization History: _____
Daily supplements: _____
Any allergies? _____
What does the child currently eat?_____
Overall sleep amount: _____hrs/24hr timespan Sleep quality: ___ Good ___ Fair ___ Poor
Where does the child sleep? _____
Number of Bowel Movements per day: _____ Any pain associated? _____
Bowel Movement Quality: _____ well-formed _____ loose _____ hard _____ mucus _____ bloody
Has your child ever been treated on an emergency basis? _____

_____
Has your child ever been in a car accident? _____
Has your child ever sustained any injuries (broken bones, sprain/strains, major falls)? _____

_____
What types of activities/sports does your child participate in? _____

_____
Please describe a day-in-the-life of your child: _____

_____
What health/wellness goals do you have for your child? _____

_____
How can we help your child today?_____

_____

_____