Family First Chiropractic
1193 Daniel Island Drive
Charleston, SC 29492

Family First Chiropractic
9217 University Blvd. C1D
North Charleston, SC 29406

Phone: 843.471.1909 / 843-553-9700
Fax: 843-553-9731

PEDIATRIC INTAKE FORM
(1 -10 years)

Date _____
Patient Name _____
Parent Name(s) _____
Address _____
City, State, ZIP _____
SSN _____Age_____ DOB _____ Sex _____
Home Phone _____ Cell _____
Email Address _____

PURPOSE FOR CONTACTING US

Reason for this visit: _____
_____

Other doctors seen for this condition? YES NO
If yes, Doctor's names & Prior treatment _____
_____
Other health problems? _____
Family health history _____
Date of last visit _____ Reason _____
Name of Pediatrician _____
Date of last visit _____ Reason _____
Prescription medications your child has taken during the past 6 month's _____
_____
Vaccination history _____

PRENATAL HISTORY

Name of midwife / obstetrician _____
Complications during pregnancy? Yes No _____
Complications during delivery? Yes No _____
Ultrasounds during pregnancy? Yes No How many _____
Medications during pregnancy/delivery? Yes No How many _____
Location of birth Hospital Birthing Center Home
Birth intervention Forceps Vacuum extraction
Caesarean Section Yes No Emergency Planned
Apgar score _____ _____
Cigarette/Alcohol during pregnancy? Yes No How much _____
Genetic disorders/disabilities? Yes No _____
Birth Weight _____ Birth Length _____

FEEDING HISTORY

Breast fed? Yes No How long _____
Formula fed? Yes No How long _____
Introduced solids? _____month's
Cow's milk _____months
Food/juice allergies/intolerances Yes No _____

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DEVELOPMENTAL HISTORY

At what age did your child:

_____months Respond to Sound
_____months Respond to Visual Stimuli
_____months Sit Up
_____months Cross Crawl
_____months Stand Alone
_____months Walk Alone

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (i.e. a bed, a changing table, down stairs, etc.) Was this the case with your child?
Yes No From where _____

Is/has your child been involved in any high impact or contact sports? Yes No
List _____
_____

Has your child ever been involved in a car accident? Yes No When _____
Has your child ever been seen on an emergency basis? Yes No
Please explain: _____
_____

Other traumas not described above? _____
_____

Prior Surgery? Yes No _____
Has your daughter started her period? Yes No How old was she? _____

CHILDHOOD DISEASES

Chicken Pox	Yes	No	_____age	Mumps	Yes	No	_____age
Rubella	Yes	No	_____age	Rubeola	Yes	No	_____age
Whooping Cough	Yes	No	_____age	Other	Yes	No	_____age

We are here to serve you and encourage you to ask questions, your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Family First Chiropractic to administer care to my son/daughter as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office if they are not covered by insurance.

Name of Insurance Company _____
Policy Number _____
Policy Holder's Name _____
Policy Holder's DOB _____/_____/_____

Parent / Guardian Name _____
Guardian Signature _____
Relationship to Minor _____
Date _____/_____/_____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____ **DOB:** _____

Email Address: _____@_____

Preferred method of communication for patient EHR reminders (Circle one): Email / Phone / Mail

Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling (circle): (brother/sister)	Offspring (circle): (son/daughter)
Example: Heart Disease				

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient/ Guardian Signature:_____ Date: _____