LYDIAN CHIROPRACTIC

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DEMOGRAPHIC INFORMATION

Name _____ Today's Date _____

Address _____ Parent Name(s) _____

City, State, Zip _____ Parent Occupations(s) _____

Phone (home) _____ _____

Date of Birth _____ Age _____ Parent Employer(s) _____

Gender: ☐ F ☐ M Height: ____ ft ____ in Weight: _____ Parent Email _____

Medical Doctor _____ Parent Work Phone _____

Date of last check-up _____ Parent Cell Phone _____

Travel time to this office _____ Referred to our office by _____

Name/Age of Sibling(s) _____

Other Household Members (include extended family, non-family and pets) _____

_____

Name of person responsible for payment of professional services _____

Practitioners at the Lydian Center you have previously seen: _____

CURRENT HEALTH REPORT

What are the primary health or developmental concerns with this child?

1. _____

2. _____

3. _____

BIRTH HISTORY

Was your child adopted? _____ If so, at what age? _____

Term: Full / Premature / Late _____ C-Section? _____ Did mother go into labor? _____ Length of Labor _____

Weight at Birth _____ Birth/fetal pregnancy complications _____

Feeding: ☐ Breast fed How long? _____ ☐ Formula ☐ Milk/Soy Solid foods at age _____

Baby's sleep pattern first year _____

Does child sleep well now? _____

As a baby did this child experience:

☐ Allergies	☐ Colic	☐ Fever	☐ Rashes
☐ Birth Injury	☐ Diarrhea	☐ Jaundice	☐ Seizures
☐ Birth Defects			

DEVELOPMENTAL HISTORY

Physical Development

Age began: Rolling over _____ Sitting _____ Crawling _____ Walking _____

Any difficulties with:

☐ Rolling Over ☐ Running ☐ Activities on a Play Structure

☐ Crawling ☐ Somersaults ☐ Gross Motor Activities

☐ Walking ☐ Climbing ☐ Fine Motor Activities

If any difficulties, please explain: _____

_____

Unusual Skills or Interests _____

Sensory Integration Issues

Sensitivity to: ☐ Light ☐ Sound ☐ Smells ☐ Tactile Stimulation ☐ Picky Eater (texture/taste)

Language Development

Age of First Words _____ Sentences _____

Daily Activities

How many hours does your child spend playing out of doors each day? _____

How many hours does your child spend on computer, TV or video time? _____

Favorite Activities: _____

Social Development

Desire and ability to communicate with:

Parents _____ Peers _____ Adults _____

Siblings _____ Older Children _____ Strangers _____

Describe his/her relationships with siblings: _____

Emotional traumas: _____

Extended family (or committed adult family friends) with whom the child has regular contact: _____

_____

Notable developmental histories of biological siblings: _____

_____

DIET

Please describe your child's typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Sweets _____

Food cravings: _____

Any known food, environmental or medication allergies/intolerances? Please list: _____

_____

Does your child routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what?

_____

Artificial colors/sweeteners? _____ Has child ever tried a gluten free/dairy free diet? _____

MEDICAL HISTORY

Injuries

Head injuries _____

Other major falls or injuries _____

Other traumatic events _____

Surgeries/Hospitalizations _____

Infections

Has your child had any of the following:

☐ Bronchitis ☐ Tonsillitis ☐ Measles ☐ Colic

☐ Croup number of times ___ ☐ Mumps ☐ Persistent Diaper Rashes

☐ Frequent Colds ☐ Ear Infections ☐ Rubella ☐ Bedwetting

☐ Pneumonia number of times ___ ☐ Antibiotic Prescriptions

☐ Chicken Pox ☐ Scarlet Fever approximate number in lifetime ____

Immunizations

Has your child had standard childhood vaccinations? ☐ yes ☐ no Any adverse reactions? Please describe:

_____

When your child's condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? _____

Symptoms

Please write: C = Constantly in the present O = Occasionally in the present P = In the past

_____ acne _____ bloody urine _____ joint pains

_____ excema _____ hearing loss _____ nervousness

_____ hives _____ heart murmur _____ dizzy spells

_____ asthma _____ anemia _____ body/breath odor

_____ high fevers _____ stomach aches _____ motion/car sick

_____ chronic rash _____ constipation _____ nightmares

_____ canker sores _____ diarrhea _____ unusual fears

_____ sore throat _____ gas _____ night sweats

_____ wheezing _____ no appetite _____ cries easily

_____ bleeding gums _____ insatiable hunger _____ inconsolable crying

_____ nose bleeds _____ jaundice _____ excessive fatigue

_____ burning urination _____ bruises easily

_____ frequent urination _____ flat feet

Any other condition not previously mentioned _____

_____

Any current medications (prescription and non-prescription)_____

_____

IMAGING AND SPECIAL STUDIES

	When	Where	Results
Hearing Test	_____	_____	_____
Vision Test	_____	_____	_____
Speech/Language	_____	_____	_____
Behavioral Assessment	_____	_____	_____
X-ray	_____	_____	_____
Other _____	_____	_____	_____

FAMILY HISTORY

Has any immediate family member had any of the following:

☐ Allergies ☐ Birth Defects ☐ Diabetes ☐ Hypertension

☐ Arthritis ☐ Cancer ☐ Heart Disease ☐ Mental Illness

Health of biological siblings _____

_____

Previous pregnancies by birth mother, miscarriages or complications _____

_____

Mother's health during pregnancy:

☐ Alcohol consumption ☐ Drug use ☐ Nausea ☐ Tobacco use

☐ Bleeding ☐ Illness ☐ Thyroid problems ☐ Diabetes

☐ Physical/emotional trauma

Mother's age at child's birth _____

Your completion of this Intake Form will help us determine whether our services might help your child. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice's services may not meet your child's needs, we may offer to discuss possible alternative practitioners at the Lydian Center. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether your child becomes a patient of the Practice.

Please note that each practitioner practicing at the Lydian Center owns and operates his/her own clinical practice and is not affiliated with Lydian Chiropractic. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek treatment and care for your child from any practitioner at any facility you choose.

Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: ☐