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: _____ _____
Medical Doctor _____ Parent Email _____
Date of last check-up _____ Parent Work Phone _____
School currently attending _____ 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, 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 _____
Sleep pattern during 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:

☐ Crawling	☐ Somersaults	☐ Throwing/Catching a Ball
☐ Walking	☐ Climbing	☐ Activities on the Playground
☐Running	☐ Riding a Bike	☐ Gross Motor Activities
☐ Hopping	☐ Swimming	☐ Fine Motor Activities
☐ Skipping	☐ Organizing/Remembering Sequential Activities or Thoughts	

If any difficulties, please explain: _____

Sensory Integration Issues

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

Language and Social Development

Age of First Words _____ Sentences _____ Is s/he reading yet? _____ Age began reading _____

How easily does s/he communicate needs and desires? _____

Is s/he cooperative? _____ Able to follow instructions? _____

Unusual skills or interests: _____

Desire and ability to communicate with:

Parents _____ Peers _____ Adults _____

Siblings _____ Older Children _____ Strangers _____

Describe his/her relationships with siblings: _____

Is s/he a Leader? _____ Follower? _____ Socially flexible? _____

Does s/he have many friends? _____ A few close friends? _____

Emotional traumas: _____

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

_____

Notable developmental histories of biological siblings: _____ _

DIET AND LIFESTYLE

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? _____

How many hours per day does your child spend:

____ hours playing outdoors (weather permitting)
____ hours of computer time
____ hours watching TV/video
____ hours of unstructured time in imaginary play
____ hours of unstructured time with friends

Favorite activities _____

_____

MEDICAL HISTORY

Injuries

Head injuries _____

Other major falls or injuries _____

Other traumatic events _____

Surgeries/Hospitalizations _____

Illnesses

Has this child had any of the following:

☐ Bronchitis
☐ Croup
☐ Frequent Colds
☐ Pneumonia
☐ Chicken Pox
☐ Tonsillitis number of times ___
☐ Ear Infections number of times ___
☐ Scarlet Fever
☐ Measles
☐ Mumps
☐ Rubella
☐ Antibiotic Prescriptions approximate number in lifetime ____
☐ Colic
☐ Persistent Diaper Rashes
☐ Bedwetting

Immunizations

☐ Chicken Pox
☐ Diphtheria
☐ DPT
☐ Hepatitis B
☐ Influenza
☐ Measles
☐ MMR
☐ Mumps
☐ Polio
☐ Smallpox
☐ Tetanus
☐ Other _____

Any adverse reactions? Please describe: _____

Symptoms

Please write either C, O or P for each: C = Constantly in the present O = Occasionally in the present P = In the past

_____ acne
_____ excema
_____ hives
_____ asthma
_____ high fevers
_____ chronic rash
_____ canker sores
_____ sore throat
_____ wheezing
_____ bleeding gums
_____ nose bleeds
_____ burning urination
_____ frequent urination
_____ bloody urine
_____ hearing loss
_____ heart murmur
_____ anemia
_____ stomach aches
_____ constipation
_____ diarrhea
_____ gas
_____ no appetite
_____ insatiable hunger
_____ jaundice
_____ bruises easily
_____ flat feet
_____ joint pains
_____ nervousness
_____ dizzy spells
_____ body/breath odor
_____ motion/car sick
_____ nightmares
_____ unusual fears
_____ night sweats
_____ cries easily
_____ inconsolable crying
_____ excessive fatigue

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: ☐