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 young person?

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 _____

Sleep pattern during first year _____

Does s/he sleep well now? _____

As a baby did s/he 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: _____

School History, Language and Social Development

Current Grade Level _____ Current Grade Level for Reading _____ Current Grade Level for Writing _____

Areas of Academic Ease _____

Areas of Academic Difficulty _____

Favorite Subjects _____

Unusual skills or interests: _____

Desire, ease 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? _____

How easily does s/he listen and cooperate with others? _____ Follow Instructions? _____

Emotional traumas: _____

Extended family (or committed adult family friends) with whom this young person has regular contact:

_____

Notable developmental histories of biological siblings: _____

Sensory Integration Issues

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

DIET AND LIFESTYLE

Please describe his/her typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Sweets _____

Food cravings: _____

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

_____

Does s/he routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what?

_____

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

How many hours per day does s/he 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 s/he 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

Has s/he had standard childhood vaccinations? ☐ yes ☐ no Any adverse reactions? Please describe:

_____

When his/her condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that? _____

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: ☐