Quantum Chiropractic: Pediatric Intake Form — Dr. Pauline Asahara

Child's Name:		Parent/Guardian:	
Street Address:		City, State, Zip:	
Cell Phone:		Other Phone:	
Email:		Gender:	Male Female
Birthdate:	___ / ___ / ______	Age:	______ Months ______ Years
Height & Weight	_____ ft. ____ in. / ______ lbs	Who is primary care physician?	

List any drugs, medications, vitamins etc.? ____

____

Is your child receiving care from another healthcare provider? yes / no
For what issue? ____

Current Health Conditions			
Primary issue to address?	______________________ ______________________ ______________________	When did the issue start?	______________________ ______________________ ______________________
Has your child had this before?	Yes / No When: ______________	Frequency?	Rare Intermittent Always
Is it getting worse?	Yes / No / Maybe		

Have you or your child ever seen a chiropractor before? Yes No If yes, why? ____________

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PREGNANCY & FERTILITY HISTORY: (Circle and explain if necessary)

Any fertility issues?	Yes	No	If yes, please explain: ____________________________
Did "mom" smoke or drink?	Yes	No	If yes, please explain: ____________________________
Did "mom" exercise?	Yes	No	If yes, please explain: ____________________________
Was "mom" ill? Morning sickness?	Yes	No	If yes, please explain: ____________________________
Any ultrasounds?	Yes	No	If yes, please explain: ____________________________
Any illnesses or infections while pregnant?	Yes	No	If yes, please explain: ____________________________

Any other comments regarding your pregnancy or fertility. ____________________________________

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LABOR & DELIVERY HISTORY (Circle and explain if necessary)

Child birth was:	*Natural vaginal birth*	*Scheduled C-section*	*Emergency C-section*
Child birth was:	*At home*	*Birth center*	*Hospital*
Please check if applicable:	*Breech*	*Induction*	*Pain meds*
Epidural	*Episiotomy*	*Vacuum Extraction*	*Forceps*

Additional Info: ________
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____
____
____
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____

APGAR Score at birth: ________ APGAR after 5 minutes: ________

Birth weight: ___ lbs. ___ oz. Child's birth height: ____ inches

GROWTH & DEVELOPMENT HISTORY (Circle and explain if necessary)

Is/was your child breastfed?	Yes No	If yes, how long?	________
Is/was breastfeeding difficult?	Yes No	If yes, explain.	________
Does your child suffer from:	Colic	Reflux	Diarrhea / Constipation
Did/does your child frequently arch their neck/back, feel stiff, or bang their head?	Yes No	If yes, explain.	________ ________
Have you chosen to vaccinate?	Yes No	Delayed schedule	Yes, on schedule / Religious exemption
Has your child been on antibiotics?	Yes No	If yes, explain.	________ ________
Does your child have trouble sleeping?	Yes No	If yes, explain.	________ ________
Behavioral, social or emotional issues?	Yes No	If yes, explain.	________ ________
How would you describe your child's diet?	Organic	Gluten Free Dairy Free	________ ________

Please list any food allergies or intolerances your child has: ________________________________
____

Please list any major issues, accidents, falls and/or fractures your child has had in his/her lifetime.
____
____

Please list your child's hospitalization and surgical history: ________________________________
____

At what age did your child start the following activities?

Respond to sound:		Follow an object:		Begin solid foods:	
Hold their head up:		Vocalize:		Walk:	
Teethe:		Sit alone:		Crawl:	

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	SYMPTOMS (PAST / PRESENT)
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Parents Name: ______________________ Signature: ____________________

Date: ____________________