GATEWAYS QUANTUM CENTER

PEDIATRIC INTAKE FORM

Child's Name:_____ Date of Birth:_____ Age:___ Today's Date:_____
Parent(s) Name(s):_____
Address:_____ City:_____ State:_____ Zip:_____
Cell Phone #:_____ Home:_____ Email:_____
Sex: ❑M ❑F Names & Ages of Siblings:_____
Emergency Contact:_____ Relationship:_____ Phone #:_____
How did you hear about us?_____
Whom may we thank for your referral?_____
Has your child seen a chiropractor before? ❑Yes ❑No Office:_____ Last visit?_____
Reason for Care:_____ Results:_____
Whom is on your child's healthcare team? (OB, Midwife, Pediatrician, other healthcare providers)_____

Our office provides wellness + embodiment & transformational care ONLY. We are not medical doctors and do not provide diagnosis, examinations, or treatment for medical conditions, complaints, or symptoms, *including pain*. Therefore, we are unable to participate in any insurance or Medicare plans or programs. We do not accept any personal injury or work comp. cases and we will not communicate with any insurance company for any reason due to the non-medical nature of the care we provide. We are unable to offer super-bills, medical coding, or exceptions of any kind to the above policies.

We honor and hold our practice members in wholeness and honor symptoms as sacred messengers and important data points for your healing journey. We provide care to help you optimize your wellness, vitality, and experience & expression of Life.

Please initial that you understand and freely choose to apply to become a practice member and, if accepted, you agree to accept these policies. _____

HEALTH PROFILE

What is the reason your child is seeking services here? ❑ Wellness ❑ Other (please describe concerns):
_____
_____
How/when did these concerns begin?_____
Has your child been treated for this symptom(s) on an emergency basis? ❑No ❑Yes:_____
Have you consulted anyone else? ❑No ❑Yes:_____
Please list any other health concerns your child may be experiencing:_____
_____
What changes in your child's health or behavior would you like to see?_____
_____
Has your child had any surgeries, hospitalizations, or medical diagnoses?_____
_____
Any nutritional or digestive concerns?_____

Please list any medications (prescription or over the counter) and/or supplements your child is using or has recently used:

Name of Medication or Supplement	Dosage	Frequency	Reason for Taking

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*If breastfeeding, is the mother on any medications or supplements? _____
Did your child receive any vaccinations? ❑Yes ❑No ❑Alternative Schedule Any poor response?_____
Has your child had any childhood illnesses? _____
Any known allergies? _____

PREGNANCY AND BIRTH OF YOUR CHILD

PREGNANCY Duration of pregnancy:_____

❑ Back/Other pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Step B ❑ Nausea/Vomiting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other:_____

Number of previous pregnancies: _____
Notable symptoms/conditions/experiences in previous pregnancies or births: _____
Any significant falls or traumas to the mother during pregnancy? ❑No ❑Yes: _____
Any significant illness to the mother during pregnancy? ❑No ❑Yes: _____

Prescription medications taken during pregnancy:_____
Over-the-Counter Medications taken during pregnancy: (ex. Tums, aspirin, etc.): _____
Nutritional supplements prescribed or taken during the pregnancy: _____

Were ultrasound(s) performed during the pregnancy? ❑Yes ❑No When/for what purpose: _____
Were any invasive procedures performed during the pregnancy? (amniocentesis, cerclage, etc.?) ❑Yes ❑No
Describe:_____

During pregnancy did the mother: Smoke? ❑Yes❑No -- Drink alcohol? ❑Yes❑No -- Use recreational drugs? ❑Yes❑No

LABOR & BIRTH Please check all that apply:

❑ Hospital ❑ Home ❑ Birthing Center
❑ OB/GYN ❑ Midwife ❑ Doula
❑ Normal/Vaginal ❑ VBAC ❑ Scheduled/Induced – how?_____
❑ Cesarean (planned) ❑ Cesarean (emergency)
❑ Breech ❑ Face or forehead presentation
❑ Epidural ❑ Forceps ❑ Vacuum Extraction ❑ Shoulder Dystocia ❑ Antibiotics
❑ Failure to Progress ❑ Cervical Lip ❑ Maternal Distress:_____

Duration of labor (total): _____ Duration of second phase (pushing): _____
Mom's Position at time of birth:_____ Position of baby during delivery: _____
How long before placenta emerged? _____ Did they assist placenta? (traction, massage, etc.) _____

BABY Length:_____ Weight:_____ Head Circumference:_____ APGAR score:_____
Please check all that apply:

❑ Antibiotics ❑ Meconium ❑Respiratory Distress ❑Incubation ❑ Failure to thrive
❑ Jaundice ❑ Congenital Anomalies: _____
❑ Silver nitrate drops in eyes ❑ Vitamin K Shot ❑ Hepatitis B Shot
❑ Extended hospitalization/NICU Please Explain:_____

Any evidence of birth strain or trauma to baby?

❑ Bruising ❑ Cord around neck/body ❑ Fast birth ❑ Excessively slow birth
❑ Misshapen Head ❑ Blood-shot eye(s) ❑ "Stuck" in birth canal ❑ Failure to thrive
❑ Other:_____

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INFANCY

Practice Member Name _____ Date of Birth _____

Any medical concerns or conditions? _____

Any feeding difficulties? _____

❑ Difficulty latching ❑ Difficulty staying latched ❑ Cracked, bleeding, or bruised nipples

Tongue Tie? ❑Yes ❑No Revision? ❑Yes, cut. ❑Yes, laser ❑No Any re-attachment? ❑Yes ❑No

Lip Tie? ❑Yes ❑No Revision? ❑Yes, cut. ❑Yes, laser ❑No Any re-attachment? ❑Yes ❑No

Infant feedings: ❑ Breast ❑ Bottle-fed Breastmilk ❑ Formula If breastfed, for how long? _____

Was formula introduced? ❑No ❑Yes, to present ❑Yes, from age (months) _____ to _____ (months)

Was cow's milk introduced? ❑No ❑Yes, to present ❑Yes, from age (months) _____ to _____ (months)

When was your baby weaned (if applicable)?_____

Have solid foods been introduced? ❑No ❑Yes – Age:_____ First foods:_____

Does the child have any food, liquid, or juice intolerances/sensitivities or allergies? ❑No ❑Yes

Describe:_____

Gassy? ❑Yes ❑No Foul-smelling? ❑Yes ❑No Any reflux/vomiting? ❑No ❑a little ❑a lot ❑projectile

Sleep well? _____ Use a pacifier? ❑Yes ❑ No

Constant crying? _____ Colic? _____

How many wet diapers per day? _____ Bowel movement frequency? _____

MILESTONES: check if achieved / circle if delayed

❑ 6 weeks	Smiling……	❑ 11 months	Crawling……
❑ 3 months	Head steady……..	❑ 12 months	2 or 3 recognizable words…….....
❑ 7 months	Sits unaided……	❑ 14 months	Walks unaided……..……
❑ 9 months	Stands unsupported……..	❑ 16 months	Holds and drinks from a cup……..

Any notable delays (not mentioned)? _____

Please describe any developmental concerns: _____

_____

SURGERIES (with age/date): **Any pins, screws, implants, or transplanted tissues?** ❑Yes ❑No

_____

_____

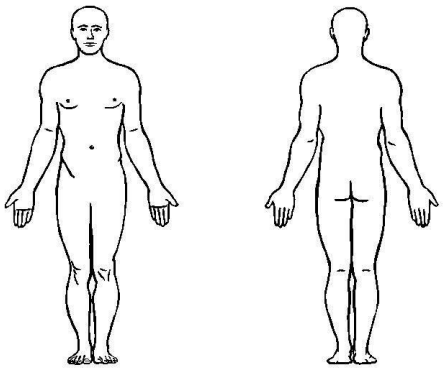
ACCIDENTS/INJURIES (with age/date – automobile, sports, playground, etc.)_____

_____

Any traumas or falls resulting in bruises, fractures, stitches? ❑No ❑Yes_____

Where are your child's scars? (draw on diagram & explain)

_____



How many siblings? _____

Has the child ever fallen on his/her tailbone? _____

Has the child ever fainted? Describe: _____

Has the child everr had a concussion, head injury, or loss of consciousness?

Describe: _____

Has the child or family experienced any major losses or emotional traumas?

_____

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CHILDHOOD

Practice Member Name _____ Date of Birth _____

Did your child receive any vaccinations? ❑Yes ❑No ❑Alternative Schedule Any poor response?_____
Do you consider their sleeping pattern normal? ❑Yes ❑No Explain:_____
Do you feel the child's social and emotional development is normal for their age? _____
Behavioral or social problems? ❑No ❑Yes Explain:_____
Hospitalizations? ❑No ❑Yes _____
Serious illness? ❑No ❑Yes _____

Has your child experienced any of the following?

❑ Delayed speech	❑ Breathing problems	❑ Vision issues	❑ Broken bones: _____
❑ Attention issues	❑ Asthma	❑ Hearing issues	❑ Backaches
❑ ADD/ADHD	❑ Chronic earaches/infections	❑ Headaches	❑ Neck problems
❑ Autism Spectrum	❑Colds/Flus	❑ Dizziness	❑ Arm problems
❑ Nervous tics	❑ Gas, Bloating	❑ Fainting	❑ Leg problems
❑ Stutter/stammer	❑ Colic	❑ Diabetes	❑ Juvenile Rheumatoid Arthritis
❑ Difficulty Sleeping	❑ Diarrhea	❑ Anemia	❑ Concussion
❑ Bed wetting	❑ Constipation	❑ Hypertension	❑ Sports Injury:_____
❑ Night terrors	❑ Urinary problems/UTI	❑ HIV/AIDS	❑ Scoliosis
❑ Sleepwalking	❑Failure to maintain eye contact	❑Convulsions/Seizures _____	
❑ Appetite/Eating problems_____		❑Joint problems_____	
❑ Skin problems_____		❑Heart trouble_____	

❑ Difficulty with child-parent bonding – Describe:_____
❑ Antibiotics – frequency and reason: _____
❑ Adverse reactions to medications or vaccines: _____

Does your child consume: ❑Caffeine ❑Soda ❑Sugar ❑Artificial Sweetener ❑Fast Food ❑Processed Food
Does the child wear a backpack? ❑Yes, heavy backpack ❑Yes, light backpack ❑No
Are there any pets in the child's home? ❑Yes ❑No Describe:_____
Are there any smokers in the child's home or environment? ❑Yes. ❑No Describe:_____

On average, how many hours per week of screen time (television, computer, tablet, electronic games, etc.)?

- ❑ 0-5 hours per week (average less than 1 hour per day)
- ❑ 6-10 hours per week (average 1 hour per day or more)
- ❑ 11-15 hours per week ! 16-20 hours per week
- ❑ 21-30 hours per week
- ❑ more than 30 hours per week

List all sports/exercise participation (include age began and # hours/week):_____
_____

Any other hobbies/activities? (Any prolonged repetitive, or unusual postures? (violin, gymnastics, ballet, etc.?)
_____

INTERNAL USE ONLY