Apex Chiropractic and Wellness Intake Form

120 Unionville Indian Trail Road C-102, Indian Trail, NC 28079
(704) 821-5000
apexchiropracticnc@gmail.com

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____
Cell Phone _____
Email _____
Sex M ☐ F ☐ Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Height _____ Weight _____
How did you hear about us? _____
Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ☐ Yes ☐ No

Please Describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia ☐ Strep B ☐ Nausea/vomiting
☐ Pre-Term ☐ Fatigue ☐ Swelling ☐ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal/Vaginal ☐ Breech

☐ Cesarean ☐ Scheduled/Induced ☐ Epidural

Problems during labor/delivery? _____

_____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice ☐ Meconium

☐ Respiratory Distress ☐ Extended Hospitalization ☐ Other _____

GROWTH AND DEVELOPMENT

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk Unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

☐ Chicken Pox ☐ Measles ☐ Rubeola

☐ Mumps ☐ Rubella ☐ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

☐ Allergies ☐ Colds/Flu ☐Heart Trouble ☐ Paralysis

☐ Anemia ☐ Colic ☐Hyperactivity ☐ Poor Appetite

☐ Arm Problems ☐ Convulsions/Seizures ☐Hypertension ☐ Ruptures/Hernias

☐ Asthma ☐ Delayed Speech ☐Juvenile RA ☐ Sinus Trouble

☐ Back Aches ☐ Diabetes ☐Joint Problems ☐ Tuberculosis

☐ Bed Wetting ☐ Digestive Issues ☐Leg Problems ☐ Walking Problems

☐ Behavioral Problems ☐ Dizziness ☐Neck Problems ☐ Other _____

☐ Broken Bones ☐ Fainting ☐Neuritis _____

☐ Chronic Ear Aches ☐ Headaches ☐Orthopedic Problems

Have you vaccinated your child?

☐ Yes ☐ No ☐ As Scheduled ☐ Delayed Schedule

SIBILINGS

How many children do you have? _____
Childrens' ages? _____
Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I'm due _____
Number of pregnancies _____
Health concerns with pregnancies? _____

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____
_____
_____

MEDICATIONS (list)

_____
_____
_____

SURGERIES (list)

_____
_____
_____

FAMILY HISTORY (list)

_____
_____
_____

Authorization for Care of Minor

I herby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter.

Signed: _____ Date: _____

Witnessed: _____ Date: _____