FULLY ALIVE
INTEGRATIVE HEALTH
Dr. Nathan Siebenaller ● Dr. Hobie Horn ● Dr. Taylor Horn
90 Commercial Way, Springboro, OH 45066 | P (937) 748-9708 | F (937) 806-4112
www.fullyaliveih.com

PEDIATRIC INTAKE FORM FOR CHILDREN AGES 9-12

HELLO AND WELCOME TO FULLY ALIVE!

Who may we thank for referring you/how did you hear about our office? _____
Why are you seeking chiropractic care for your child? □Wellness □Specific Condition
*If condition, please *briefly* describe:

Has your child received chiropractic care in the past? □Yes □No
*If YES, what was the reason for the care? _____
*From whom did your child receive care? _____
*Approximate date of last visit: _____

About the Child

Name: _____
□Male □Female
Date of Birth: _____
Age: _____
Weight: _____
Address: _____
City: _____ Zip: _____
MD/Pediatrician: _____
*May we communicate with this physician about your child's health information? □Yes □No

About the Parents

Mother: _____
Phone: _____
Father: _____
Phone: _____
Marital Status: □Single □Married □Divorced
E-mail: _____
Emergency Contact #: _____
Emergency Contact Name:
_____

Pre-Natal/Child Health History

During pregnancy did you use: □Caffeine □Medications □Alcohol/Tobacco/Drugs □Supplements
*If yes, please explain: _____
Did you experience any illnesses OR traumatic events while pregnant? □Yes □No
*If yes, please explain: _____
Was the Delivery: □Non-medicated □Chemically Induced □C-Section □Forceps/Vacuum □Premature
*Please explain: _____
Describe any genetic conditions your child has been diagnosed with: _____
Has your child ever been hospitalized/had surgery? □Yes □No *If yes, explain: _____
Any serious physical traumas (falls, car accidents, etc)? _____
Describe any broken bones your child has had: _____
Did you choose to vaccinate your child? □Yes □No *If Yes, □Delayed Schedule □Pediatrician Schedule
*Explain any adverse reaction to vaccine(s):

Child Health History Cont.

Has your child ever taken antibiotics? □Yes □No *If yes, explain: _____
Child's current or former medications: _____
List any vitamins/supplements your child takes: _____
Is your child regularly exposed to second-hand smoke? □Yes □No
For females: Has your child begun menstruating? □Yes □No *If yes, age of first cycle: _____
Please check each condition that your child now has, or formally had:
□Anxiety □Asthma □Autism □Bed Wetting □Constipation □Diarrhea □Difficulty gaining weight
□Depression □Difficult/painful/irregular menstrual cycles □Ear Infections □Headaches □Hyperactivity
□Frequent colds/coughs □Learning Disability □Physical Pain (list location: _____)
□Sleeping difficulties □Seizures □Skin Rashes □UTIs □ Other concerns:_____
_____
What activities is your child involved in? _____
Please rate your child's average daily stress level on a scale of 1-10 (10=highest): 1 2 3 4 5 6 7 8 9 10
How does your child do in school? _____
Are you aware of any food or juice allergies/intolerances? _____
Does your child eliminate stool each day? □Yes □No List your child's typical breakfast: _____
Lunch? _____ Dinner? _____
Snacks? _____ Drinks? _____

-If you are bringing in your child for <u>wellness care</u>, you may skip to GOALS-

Reason For This Visit

Describe your chief reason for bringing your child in for care: _____
When did this condition begin? _____
Has this condition: □Gotten Worse □Stayed Constant □Come & Gone
What life functions does this condition interfere with? _____
What seems to make it worse? _____
What seems to make it better? _____
Have you seen other medical professionals for this condition? □Yes □No
*If yes, who? _____ Type of Treatment: _____
Results of Treatment: _____
Please describe any additional concerns you want Dr. Siebenaller to know about:

Goals

What changes (if any) in your child's health or behavior would you like accomplished? _____
_____

Please attach any additional documentation you deem relevant for your child's appointment to this paperwork.

I certify that the above information is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____
Paren/Guardian Printed Name: _____