ASCEND
CHIROPRACTIC

Date: _____

**Patient # _____**

# New Patient Intake Form

**1-18 Years of Age**

_____

Child's First Name | Child's Last Name | Age | Date of Birth | Sex

_____

Parent/Guardian's Name | Relation to Child

Primary Phone Number: _____ **HOME** **CELL**

Please list any other health professionals they're receiving care from and their specialty:

_____

**Chief Complaint**

Please list the main reason for bringing your child into **Ascend Chiropractic:**

_____

When did this issue begin? _____

How often does this issue occur? ☐**Constantly** ☐**Comes and goes**

How much does it affect daily activities/routines? ☐**Not at all** ☐**Somewhat** ☐**Often** ☐**All the time**

**History**

Please list the main reason for bringing your child into **Ascend Chiropractic:**

_____

Does your child have any food allergies? ☐**YES** ☐**NO** If yes, please list: _____

Has your child been immunized according to the recommended schedule? ☐**YES** ☐**NO**

If yes, did they have any negative reactions? ☐ **YES** ☐ **NO** If yes, were they reported? ☐ **YES** ☐ **NO**

Has your child ever had any surgeries? ☐ **YES** ☐ **NO** If yes, explain:

_____

Has your child ever been on antibiotics? ☐ **YES** ☐ **NO** If yes, how many rounds? _____ Reason?

_____

Is your child currently taking any medications? ☐ **YES** ☐ **NO** If yes, what type?

_____

Is your child currently taking any vitamins? ☐ **YES** ☐ **NO** If yes, what type?

_____

**Have any of the following occurred?**

☐ Fall from a tree ☐ Car accident ☐ Allergies/asthma ☐ Leg/knee pain

☐ Fall off a bicycle ☐ Autism ☐ Hyperactivity ☐ Sports injury/accident

☐ Bed wetting ☐ Scoliosis ☐ Stomach pains ☐ Learning difficulties

☐ Fall off of a playground unit ☐ Other: _____

If any are checked, please explain: _____

**Please check any sports your child plays:**

☐ Soccer ☐ Football ☐ Gymnastics ☐ Lacrosse ☐ Basketball

☐ Dance ☐ Karate ☐ Hockey ☐ Wrestling ☐ Tennis

☐ Rugby ☐ Volleyball ☐ Swimming ☐ Baseball/softball

☐ Other: _____

Please check all health issues your **child** has experienced in the last **6 months**, even if they do not seem to relate to any current problem(s):

☐ Allergies ☐ Headaches/migraine ☐ Loss of smell ☐ Ringing in ears

☐ Asthma ☐ Heartburn ☐ Loss of taste ☐ Shortness of breath

☐ Cancer ☐ High blood pressure ☐ Low back pain ☐ Shoulder pain

☐ Constipation ☐ Hip pain ☐ Menstrual pain ☐ Sinus congestion

☐ Depression ☐ Indigestion/gas ☐ Mood swings ☐ Sleeping problems

☐ Diabetes ☐ Irregular cycle ☐ Neck pain/stiffness ☐ Sore throat

☐ Diarrhea ☐ Irritability ☐ Nervousness ☐ Stomach pains

☐ Dizziness ☐ Knee pain ☐ Numbness in fingers ☐ Swollen joints

☐ Fatigue ☐ Light bothers eyes ☐ Pins/needles in arms/hands ☐ Tension/anxiety

☐ Fainting ☐ Loss of balance ☐ Pins/needles in legs/feet ☐ Upper back pain

☐ Frequent urination ☐ Loss of memory ☐ Poor concentration ☐ Ulcers

Please check any conditions that your child's **family members** have had in the past or currently have (including siblings, parents, and grandparents):

☐ AIDS ☐ Diabetes ☐ Malaria ☐ Polio ☐ Cancer

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Emphysema | ☐ Measles | ☐ Rheumatic fever | ☐ Pneumonia |
| ☐ Anemia | ☐ Epilepsy/Seizures | ☐ Multiple Sclerosis | ☐ Scarlet fever | ☐ Typhoid fever |
| ☐ Appendicitis | ☐ Gout | ☐ Mumps | ☐ Stroke | ☐ Hyperthyroidism |

How would you rate your child's diet? ☐Well balanced ☐Average ☐High amounts of sugar/processed foods

How many ounces of water does your child drink per day? _____

Does your child drink milk? ☐ **YES** ☐ **NO** If yes, how much per day? _____

Number of hours your child sleeps: _____ / night and, if applicable, _____ / day (naps)

Has your child been diagnosed with any other diseases/disorders? ☐ **YES** ☐ **NO**

If yes, please list: _____

Is there anything else we should know about your child? _____

_____

_____

_____

## AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Austin Krantz of **Ascend Chiropractic** to administer care as he deems necessary to my child. I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Signed: _____ Date: _____