Colucci Chiropractic & Wellness Center

1806 Trolley Road
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Phone (843) 875-5700 Fax (843) 873-8591

Pediatric Intake Information (Confidential):

Date:________________
Name:____
SS #:____/____/____
Date of Birth: ____/____/____
Current: Height_____ Weight_____
Check one: Female____ Male____

Parent/Guardian
Name:____
Address:_____________________________________ City:_______________
State:___ Zip Code:______ Home Phone:________________________
Work Phone:___________________ Cell Phone:_________________

Who may we thank for referring you to us?_______________________________

HEALTH HISTORY
Does your child currently have or have they previously had any of the following symptoms:
(Circle all that apply)

Nervousness	Headaches	Ear Infections
Tension	Asthma	Fainting
Dizziness	Shortness of Breath	Colic
Fatigue	Chest Pain	Acid Reflux
Loss of Balance	ADD/ADHD	Excessive Spitting Up
Ringing/Buzzing in Ears	Neck Pain	Urinary Problems
Cold Sweats	Neck Stiffness	Bed Wetting
Fever	Mid Back Pain	Constipation
Arm Pain	Low Back Pain	Diarrhea
Cold Hands	Leg Pain	Upset Stomach
Light Sensitivity to Eyes	Cold Feet	Ulcers
Allergies	Sleeping Problems	Irritability

Chief Health Concerns:____
____
____

List other types of care undergone for this complaint, including medications:_______________
____
____

Date of onset:________________________ Circle One: Sudden or Gradual

Associated with an event:____

Duration of problem (episode):_________________
How often do you notice the symptoms? Constantly Frequently Occasionally

Does anything alleviate the symptoms?______________________________
Is the condition getting worse? Yes No

Effects of problems on body function and daily activities:
____
____

Was there an injury or fall? No____ Yes____ If yes, describe_____________________________

Have you had x-rays before? No_______ Yes_____ If yes, when?__________________________
What areas?____

List any other concerns:
____

History of Birth: (circle one)
Hospital Birthing Center House Midwife
Birth Weight:______
Duration of Gest2016ation:_______Weeks

Was the birth assisted:
No_____ Yes_____ If yes, circle one: Forceps Vacuum C-section Induced labor

Evidence of Birth Trauma: (i.e., bruises, odd shaped head, stuck in birth canal, fast or excessively long labor, respiratory depression, cord around neck)____

Medication delivered to mother at birth? No___ Yes___ If yes, what medication___________________
Duration of labor:_______
Complications at birth: No_____ Yes___ If yes, explain:____

Growth and Development:
Was the infant alert and responsive within twelve hours of delivery?
Yes_____ No_____ If no, explain:____

At what age did the child: Hold head up:________Sit alone:_________ Crawl:_________ Walk:_________

Do your child's sleeping patterns seem normal to you?
Yes_____ No_____ If no, explain why:____

Chemical Stressors:
Was/is the baby breast-fed? Yes, for how long?_______
No, explain reason:____

Formula introduced at age:_____ Type of formula used:___________________

Cow's milk introduced at age:_____ Began solid food at age:_____ Type:___________________
Food/Juice intolerance: No_____ Yes____ If yes, what type:___________________

During pregnancy did the mother: Smoke? No_____ Yes_____
Drink Alcohol? No_____ Yes_____

Supplements taken during pregnancy:___________________________________/None
Drugs taken during pregnancy:___________________________________/None
Any other complications during pregnancy:___________________________________/None
Has your child received vaccinations: No_____ Yes, which ones and any reactions?___________
____
Has your child received antibiotics: No_____ Yes, total courses of antibiotics to date?__________
____
Current medications and reasons:____
____/None
Surgical History:____/None

By signing below, I hereby authorize Drs. Colucci & whomever he/she may designate as assistants to administer treatment as deemed necessary to my son/daughter, (insert minor's name)_________________________________

Signature:_________________________________(Parent or Guardian)
Date:___________