Child Intake Form

Child's Name: First _____________________ MI _____ Last ______________________________ Age: _________
Address: ____________________________________ City: _____________________ State: _____ Zip: _________
Parent(s)/Guardian(s): ____
Home Phone: _________________________ Cell Phone: __________________________ DOB: _______________
Siblings Name(s) & Age(s): ____

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Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? ____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO ALIGN

Briefly describe the chief area of complaint, including the effect it has had on your child's life: _______________

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Since the problem started, is it: ❑ About the same ❑ Getting better ❑ Getting worse
What makes it worse? ____
Does it interfere with: ❑ Sleep ❑ Walking ❑ Sitting ❑ Hobbies ❑ Play
Does he/she suffer from any condition other than that which you are now consulting us? Yes / No
Please explain: ____
When did this problem first appear? ____________________ Has he/she experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) ____
Medical Doctor(s) ____
Has anyone in your family experienced similar problems? Yes / No If so, who? __________________________
Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications is your child currently taking? _____________________________

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Has your child ever been knocked unconscious? Yes / No Explain _____________________________________

BODY SIGNALS

Please check ALL symptoms your child has ever had, even if they do not seem related to the current problem:

❑ Headaches	❑ Pins and needles in legs	❑ Fainting	❑ Neck pain
❑ Pins and needles in arms	❑ Colds	❑ Back pain	❑ Loss of balance
❑ Dizziness	❑ Buzzing in the ears	❑ Ear infections	❑ Nervousness
❑ Numbness in fingers	❑ Numbness in toes	❑ Loss of taste	❑ Upset stomach
❑ Fatigue	❑ Depression	❑ Irritability	❑ Tension
❑ Sleeping problems	❑ Neck stiffness	❑ Bronchitis	❑ Asthma
❑ Diarrhea	❑ Constipation	❑ Fever	❑ Continence
❑ Cold sweats	❑ Lights bother eyes	❑ Enuresis (bed wetting)	❑ Heartburn
❑ Mood swings	❑ Allergies	❑ Ulcers	❑ Colic

Poor posture leads to poor health and often indicates a spinal condition.
How would you rate your child's posture (circle)? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent
Describe anything significant about the birth of the child: ____

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Patient's/Guardian's Signature:____Date: ______________

feel better. live well.

2399 W. Wayzata Blvd. Suite 200 Long Lake, MN 55356 | 952-476-2260 | AlignMN.com