PRIMARY CARE
CHIROPRACTIC

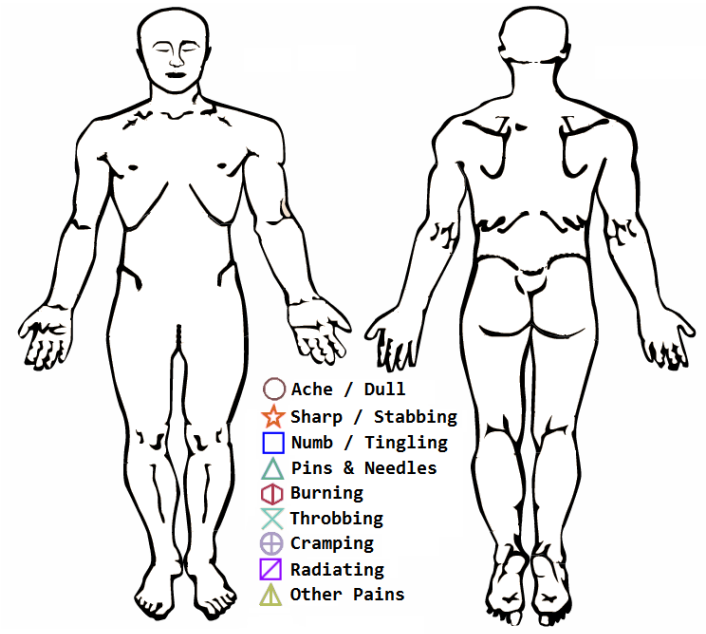
Dr. Mike Munro
14500 S. Outer 40, Suite 100
Town and Country, MO 63017
314-485-8058

CTintake

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Symptoms:



Standard Pediatric Evaluation:

Is there a history of any problems that the doctor should know about? Choose all that apply.

- ☐ No problems
- ☐ Acid reflux
- ☐ ADD
- ☐ ADHD
- ☐ Arm or shoulder condition
- ☐ Asperger's
- ☐ Autism
- ☐ Cerebral palsy
- ☐ Colic
- ☐ Congenital anomalies
- ☐ Difficulty eating
- ☐ Difficulty walking
- ☐ Down's syndrome
- ☐ Ear infection (chronic)
- ☐ Enuresis (bedwetting)
- ☐ Epilepsy
- ☐ Febrile convulsions
- ☐ Fever
- ☐ Foot flare
- ☐ Headache
- ☐ Hearing difficulties
- ☐ Inability to thrive
- ☐ Jaundice
- ☐ Seizures
- ☐ Sleeping problems
- ☐ Speech difficulties
- ☐ Vision difficulties
- ☐ Torticollis
- ☐ OTHER

Delivery type: _____ Single/multiple birth: _____ APGAR score (5 minutes after birth): _____

Were forceps used in the delivery process? _____ Was vacuum extraction used in the delivery process? _____

Labor duration (hrs): _____ Birth weight (lbs): _____ Length of the child at birth (in): _____

Pushing duration (mins): _____ Birth weight (oz): _____ Gestational age (weeks): _____

Which vaccines has the child had to date? Choose all that apply.

- ☐ Received all childhood vaccinations on schedule
- ☐ Was not vaccinated
- ☐ Diphteria (separate)
- ☐ DTP (Diphteria, Tetanus, Pertussis combination)
- ☐ Haemophilus Influenza type B (HbCV)
- ☐ Hepatitis B (HBV)
- ☐ Human Papillomavius (HPV, Gardasil)
- ☐ Influenza (flu)
- ☐ Measles (separate)
- ☐ MMR (combination)
- ☐ Mumps (separate)
- ☐ Neisseria Meningitis
- ☐ Pertussis (separate)
- ☐ Pneunococcus (Prevnar)
- ☐ Polio (OPV, IPV)
- ☐ Rubella (separate)
- ☐ Tetanus (separate)
- ☐ Varicella
- ☐ OTHER

Intensive Pediatric Evaluation:

Physical Stressors:

Were there any significant falls or traumas to the mother during the pregnancy? ◯ Yes ◯ No ◯ Unsure

List any evidence of birth trauma:

☐ Bruising ☐ Cord around neck ☐ Fast or slow birth ☐ None ☐ Odd-shaped head

☐ Respiratory depression ☐ Stuck in birth canal ☐ Unknown/unsure ☐ OTHER

Does the child have any history of serious falls or injuries, including fractures, concussions, hospitalizations, etc.? ◯ Yes ◯ No ◯ Unsure

Does the child wear a backpack? _____

Does child participate in sports or exercise activities? _____

Does child engage in any hobbies or activities which require prolonged, awkward or repetitive postures (violin, gymnastics, ballet, etc.)?

◯ Yes ◯ No ◯ Unsure ◯ OTHER

Chemical Stressors:

As an infant, was the child breastfed? ◯ Yes, until... ____ months ◯ Yes, still breast feeding ◯ No ◯ Unsure

Was formula introduced? ◯ Yes, at... ____ months ◯ No ◯ Unsure ◯ OTHER

Was cow's milk introduced? ◯ Yes, at... ____ months ◯ No ◯ Unsure ◯ OTHER

Have solid foods been introduced? ◯ Yes, at... ____ months ◯ No ◯ Unsure ◯ OTHER

Does the child have any food, liquid or juice intolerances or allergies? ◯ Yes ◯ No ◯ Unsure ◯ OTHER

During the pregnancy, did the mother smoke? ◯ Yes ◯ No ◯ Unsure

During the pregnancy, did the mother drink alcohol? ◯ Yes ◯ No ◯ Unsure

During the pregnancy, did the mother use recreational drugs? ◯ Yes ◯ No ◯ Unsure

Did the mother suffer any illnesses during the pregnancy? ◯ Yes ◯ No ◯ Unsure ◯ OTHER

Were any nutritional supplements prescribed or taken during the pregnancy? ◯ Yes ◯ No ◯ Unsure

Were ultrasound(s) performed during the pregnancy? ◯ Yes ◯ No ◯ Unsure

Were any invasive procedures performed during the pregnancy (Amniocentesis, Cerclage, etc.)? ◯ Yes ◯ No ◯ Unsure

Are there any pets in the child's home? ◯ Yes ◯ No ◯ Unsure

Are there any smokers in the child's home or environment? ◯ Yes ◯ No ◯ Unsure

Has the child had any adverse reactions to vaccinations or medicines? ◯ Yes ◯ No ◯ Unsure

Is there any history of antibiotics given to the child? ◯ Yes ◯ No ◯ Unsure

Psychosocial Stressors:

Have there been any difficulties with child-parent bonding? ◯ Yes ◯ No ◯ Unsure

Does the child have any behavioral problems? ◯ Yes ◯ No ◯ Unsure

Have any of the following behaviors occurred? Check all that apply.

☐ Attention issues ☐ Bedwetting ☐ Difficulty sleeping ☐ Failure to maintain eye contact

☐ Hearing issues ☐ Nervous tics ☐ Night terrors ☐ Sleepwalking

☐ Stutter or stammer ☐ Unsure ☐ OTHER

On average, how many hours per week of television does the child watch? _____

Do you feel the child's social and emotional development is normal for their age? ◯ Yes ◯ No ◯ Unsure

Was there any delay in terms of the child's achievement of developmental goals? Choose all that apply.

☐ None, all developmental goals were met on schedule

☐ Delayed response to sound ☐ Delayed ability to follow an object ☐ Delayed ability to hold head up ☐ Delayed ability to vocalize

☐ Delayed ability to sit alone ☐ Delayed normal appearance of teeth ☐ Delayed ability to crawl ☐ Delayed ability to walk

☐ Unsure ☐ OTHER

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____