|  |  |
| --- | --- |
| **A screenshot of a cell phone  Description automatically generatedWellSpring: Integrative Health Care**3221 S Cherokee Lane Ste 1830Woodstock, Ga 30188Tel: 770.376.0632 Secure fax: 770.783-6338 |  |

**DEMOGRAPHIC INFORMATION**

Name Today’s Date

Address Parent Name(s)

City, State, Zip Parent Occupations(s)

Phone (home)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Parent Employer(s)

Gender: □ F □ M Height: \_\_\_\_ ft \_\_\_\_ in Weight: Parent Email

Medical Doctor Parent Work Phone

Date of last check-up Parent Cell Phone

Travel time to this office Referred to our office by

Name/Age of Sibling(s)

Other Household Members (include extended family, non-family and pets)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person responsible for payment of professional services

Practitioners at the Lydian Center you have previously seen:

**CURRENT HEALTH REPORT**

What are the primary health or developmental concerns with this child?

1.

2.

3.

**BIRTH HISTORY**

Was your child adopted? \_\_\_\_\_\_\_\_ If so, at what age? \_\_\_\_\_\_\_\_

Term: Full / Premature / Late \_\_\_\_\_ C-Section? \_\_\_\_\_\_ Did mother go into labor? \_\_\_\_\_\_ Length of Labor

Weight at Birth \_\_\_\_\_\_\_\_ Birth/fetal pregnancy complications

Feeding: □ Breast fed How long? \_\_\_\_\_\_ □ Formula □ Milk/Soy Solid foods at age

Baby’s sleep pattern first year

Does child sleep well now?

As a baby did this child experience:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Allergies | □ Colic | □ Fever | □ Rashes |
| □ Birth Injury | □ Diarrhea | □ Jaundice | □ Seizures |
| □ Birth Defects |  |  |  |

**DEVELOPMENTAL HISTORY**

**Physical Development**

Age began: Rolling over \_\_\_\_\_\_\_\_\_\_\_\_\_ Sitting \_\_\_\_\_\_\_\_\_\_\_\_\_ Crawling \_\_\_\_\_\_\_\_\_\_\_\_\_ Walking

Any difficulties with:

|  |  |  |
| --- | --- | --- |
| □ Rolling Over | □ Running | □ Activities on a Play Structure |
| □ Crawling | □ Somersaults | □ Gross Motor Activities |
| □ Walking | □ Climbing | □ Fine Motor Activities |

If any difficulties, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unusual Skills or Interests

**Sensory Integration Issues**

Sensitivity to: □ Light □ Sound □ Smells □ Tactile Stimulation □ Picky Eater (texture/taste)

**Language Development**

Age of First Words \_\_\_\_\_\_\_\_\_ Sentences \_\_\_\_\_\_\_\_

**Daily Activities**

How many hours does your child spend playing out of doors each day?

How many hours does your child spend on computer, TV or video time?

Favorite Activities:

**Social Development**

Desire and ability to communicate with:

Parents Peers Adults

Siblings Older Children Strangers

Describe his/her relationships with siblings:

Emotional traumas:

Extended family (or committed adult family friends) with whom the child has regular contact:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notable developmental histories of biological siblings:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET**

Please describe your child’s typical daily diet:

Breakfast

Lunch

Dinner

Snacks

Sweets

Food cravings:

Any known food, environmental or medication allergies/intolerances? Please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child routinely eat processed foods (bologna, sausage, processed cheese, baked goods)? If so, what?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Artificial colors/sweeteners? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has child ever tried a gluten free/dairy free diet?

**MEDICAL HISTORY**

**Injuries**

Head injuries

Other major falls or injuries

Other traumatic events

Surgeries/Hospitalizations

**Infections**

Has your child had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Bronchitis | □ Tonsillitis | □ Measles | □ Colic |
| □ Croup |  number of times \_\_\_ | □ Mumps | □ Persistent Diaper Rashes |
| □ Frequent Colds | □ Ear Infections | □ Rubella | □ Bedwetting |
| □ Pneumonia |  number of times \_\_\_ | □ Antibiotic Prescriptions |  |
| □ Chicken Pox | □ Scarlet Fever |  approximate number in lifetime \_\_\_\_ |

**Immunizations**

Has your child had standard childhood vaccinations? □ yes □ no Any adverse reactions? Please describe:

When your child’s condition first appeared, about how long was it after their most recent vaccination, and which vaccination was that?

**Symptoms**

Please write: **C** = Constantly in the present **O** = Occasionally in the present **P** = In the past

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_ acne | \_\_\_\_\_ bloody urine | \_\_\_\_\_ joint pains |
| \_\_\_\_\_ excema | \_\_\_\_\_ hearing loss | \_\_\_\_\_ nervousness |
| \_\_\_\_\_ hives | \_\_\_\_\_ heart murmur | \_\_\_\_\_ dizzy spells |
| \_\_\_\_\_ asthma | \_\_\_\_\_ anemia | \_\_\_\_\_ body/breath odor |
| \_\_\_\_\_ high fevers | \_\_\_\_\_ stomach aches | \_\_\_\_\_ motion/car sick |
| \_\_\_\_\_ chronic rash | \_\_\_\_\_ constipation | \_\_\_\_\_ nightmares |
| \_\_\_\_\_ canker sores  | \_\_\_\_\_ diarrhea | \_\_\_\_\_ unusual fears |
| \_\_\_\_\_ sore throat | \_\_\_\_\_ gas  | \_\_\_\_\_ night sweats |
| \_\_\_\_\_ wheezing | \_\_\_\_\_ no appetite | \_\_\_\_\_ cries easily |
| \_\_\_\_\_ bleeding gums | \_\_\_\_\_ insatiable hunger | \_\_\_\_\_ inconsolable crying |
| \_\_\_\_\_ nose bleeds | \_\_\_\_\_ jaundice | \_\_\_\_\_ excessive fatigue |
| \_\_\_\_\_ burning urination | \_\_\_\_\_ bruises easily |  |
| \_\_\_\_\_ frequent urination | \_\_\_\_\_ flat feet |  |

Any other condition not previously mentioned

Any current medications (prescription and non-prescription)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMAGING AND SPECIAL STUDIES**

 When Where Results

Hearing Test \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Vision Test \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Speech/Language \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Behavioral Assessment \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

X-ray \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Has any immediate family member had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Allergies | □ Birth Defects | □ Diabetes | □ Hypertension |
| □ Arthritis | □ Cancer | □ Heart Disease | □ Mental Illness |

Health of biological siblings

Previous pregnancies by birth mother, miscarriages or complications

Mother’s health during pregnancy:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Alcohol consumption | □ Drug use | □ Nausea | □ Tobacco use |
| □ Bleeding | □ Illness | □ Thyroid problems | □ Diabetes |
| □ Physical/emotional trauma | Mother’s age at child’s birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Your completion of this Intake Form will help us determine whether our services might help your child. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice’s services may not meet your child’s needs, we may offer to discuss possible alternative practitioners at the Lydian Center. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether your child becomes a patient of the Practice.

Please note that each practitioner practicing at the Lydian Center owns and operates his/her own clinical practice and is not affiliated with Lydian Chiropractic. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek treatment and care for your child from any practitioner at any facility you choose.

**Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: □**