bloomington wellness center
Twin Cities Scoliosis Center
952.881.2800 office
5143 w 98th street
bloomington, mn 55437
wellbloomington.com

Pediatric Intake Form

Case History for Children 12 & Under (page 1 of 2)

Child's Name:_____ Date of Birth: _____/_____/_____
Mother's Name: _____
Father's Name: _____

Health Objectives

Chief health concern? (describe in detail) _____

_____

Other health concerns? _____

_____

As the parent or guardian, what strategies could you employ to help ensure the future health of your child?

_____

Prenatal History

As many childhood and adult health problems arise from pregnancy or through events occurring during labor and delivery, the following information is vital in determining the onset of illness or injury.

Problems during pregnancy? _____

Was there *alcohol, smoking, illicit, prescription or over-the-counter drug use* during pregnancy? **Y / N / Unsure**

If **Yes**, please list: _____

Circle type of birth: **Vaginal / Forceps / Vacuum / Breech / Cesarean** - **Planned** or **Emergency**

Problems during labor/delivery? _____

Was there medication or anesthesia used during labor or delivery? **Y / N / Unsure**

If **Yes**, please list: _____

Did the provider assist delivery with their hands? **Y / N / Unsure**

If **Yes**, did he/she turn or pull the baby's head? **Y / N / Unsure**

Was there any visible injury to the baby after delivery? **Y / N / Unsure**

If **Yes**, please describe: _____

Weeks Gestation at Birth: _____ Birth Weight: _____ Birth Length: _____

Developmental History

At what age was your child able to respond to:

Sound:_____ Visual Stimuli:_____ Hold Head Up:_____ Sit Up:_____
Cross Crawl:_____ Stand Alone:_____ Walk Alone:_____ First Words:_____

Are you concerned about any developmental delays? **Y / N**

If **Yes**, please list: _____

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Feeding History

Was your child breast fed? **Y / N** If **Yes**, how long?_____ Was your child formula fed? **Y / N** If **Yes**, how long?_____
If formula fed, list type(s) of formula used and reason for each: _____

_____

Introduced to solids at: _____ months. Cows milk at: _____ months.
Does your child have food or juice allergies or intolerances? **Y / N** If **Yes**, please list:

_____

Please briefly describe your child's current diet: _____
How could their diet be changed for the better? _____

Health History

According to the International Safety Council, 50% of children have fallen onto their heads during their 1st year of life. Another study reveals ¼ million children are injured on playgrounds annually.

Has your child experienced any such jolts, falls, or traumas? **Y / N** If **Yes**, please describe: _____

_____

Please check any of the following conditions your child has suffered from past and present:

___Allergies	___Chicken Pox	___Fatigue	___Meningitis	___Rubeola
___Asthma	___Colds	___Fevers	___Mumps	___Seizures
___ADHD / ADD	___Colic	___Growing Pains	___Neck Pain	___Scoliosis
___Back Pain	___Diarrhea	___Headaches	___Poor Posture	___Sleeping Disorders
___Bedwetting	___Digestive Problems	___Irritability	___Rashes	___Whooping Cough
___Breathing Problems	___ Ear Infections	___Measles	___Rubella	___Other:_____

Please list all past and present athletic activities your child has participated in: _____
Has your child ever been involved in an automobile accident? **Y / N** If **Yes**, please list: _____
Has your child ever been seen on an emergency basis? **Y / N** If **Yes**, please list: _____
List any other traumas, surgeries and/or hospitalizations: _____
Please list all past and present drug treatments your child has received (Prescription & over-the-counter)
and reasons for each: _____
Does your child spend prolonged time sitting? **Y / N** Approximate hours a day: _____
Has your child been screened by a doctor skilled in the detection of scoliosis? **Y / N / Unsure**
Was your child vaccinated? **Y / N** If **Yes:** Full Schedule / Partial
Did your child experience any immediate or delayed adverse reactions? **Y / N / Unsure**
If **Yes**, please describe: _____
On a scale of **0 - 10** describe your child's stress level: **(0 = None / 10 = Extreme)**
On a scale of **0 - 10** describe your child's: **(0 = Poor / 10 = Excellent)**

Exercise: _____ Sleep: _____ Diet: _____ Emotional Health: _____ Overall Health: _____