Dr. David Krohse
515.309.1217

12337 Stratford Drive
Clive, IA 50325

Child/Pediatric Intake Form

Date:__________________ Patient #___________

PERSONAL INFORMATION

Name: First __________________ MI ________ Last____________________ Height: ________ Weight: _______

Age:_______ Birth Date:___________ Social Security #_________________________

Parents/Guardians:____ Primary Phone:_______________

Second Phone: _________________ Office Phone: ____________________ Email: ________________________

Address:____________________________________City:___________________ State:______ Zip:___________

Emergency Contact:____ Phone:_______________

How were you referred to our office?____

Family Medical Doctor:____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your child's care at this office?___________

HISTORY OF PRESENT ILLNESS

Chief Complaint(s): Purpose of this appointment:____

Date symptoms appeared or accident happened:____

Is this due to: Auto___ Work____ Other ____

Has child ever had the same or a similar condition? ☐Yes ☐ No If yes, when and describe:______________

____

Days of school missed:_______________ Date of last physical examination:_______________________________

PAST MEDICAL HISTORY

Has child had any major illnesses, injuries, falls, auto accidents or surgeries? (include dates):

____

____

Has child been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:____

What medications or drugs is child taking? ___________________)______________________________________

____

Does child have any allergies to any medications? ☐ Yes☐ No

If yes, describe:____

Does child have any allergies of any kind? ☐ Yes☐ No

If yes, describe:____

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PAST MEDICAL HISTORY

Check the following conditions child had:

_____	Ear Infections	_____	Diabetes	_____	Measles	_____	Stroke
_____	Anemia	_____	Diphtheria	_____	Multiple Sclerosis	_____	Tonsilitis
_____	Appendicitis	_____	Eczema	_____	Mumps	_____	Tuberculosis
_____	Arteriosclerosis	_____	Emphysema	_____	Pleurisy	_____	Typhoid Fever
_____	Asthma	_____	Epilepsy	_____	Pneumonia	_____	Venereal Disease
_____	Cancer	_____	Goiter	_____	Polio	_____	Whooping Cough
_____	Chicken Pox	_____	Heart Disease	_____	Rheumatic Fever	_____	_______________
_____	Cold Sores	_____	Hypoglycemia	_____	Scarlet Fever	_____	_______________

REVIEW OF SYSTEMS

Check any of the following symptoms child has now (N) or had in the Past (P)

N	P	General
___	___	Severe or frequent headaches
___	___	Sinus Infections
___	___	Frequent Colds
___	___	Depression
___	___	Loss of Sleep
___	___	Loss of Weight
___	___	Nervousness
___	___	Tremors
___	___	Arthritis
___	___	Bursitis
___	___	Dizziness
		Pain/Numbness in:
___	___	Neck
___	___	Upper Back
___	___	Shoulders
___	___	Elbows
___	___	Hands
___	___	Lower Back
___	___	Hips
___	___	Legs
___	___	Knees
___	___	Feet
___	___	Sciatica (down back of leg)
		Gastro-Intestinal
___	___	Belching/Gas
___	___	Ulcer/Colitis
___	___	Constipation
___	___	Diarrhea
___	___	Liver Trouble
___	___	Gall Bladder Trouble
___	___	Acid Reflux/Difficult Digestion
___	___	Jaundice
		Skin
___	___	Bruise Easily
___	___	Hives or Allergy
___	___	Itching or Rashes

N	P	Eyes, Ears, Nose, Throat
___	___	Deafness
___	___	Earache
___	___	Eye Pain
___	___	Hay Fever
___	___	Sore Throat
___	___	Nasal Obstruction
___	___	Hoarseness
___	___	Nosebleeds
		Cardiovascular
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Cold Hand/Feet
___	___	Heart Surgery/Pacemaker
___	___	Rapid/Slow Beating Heart
___	___	Swelling Ankles
___	___	Varicose Veins
		Respiratory
___	___	Chest Pain
___	___	Chronic Cough
___	___	Difficulty Breathing
___	___	Wheezing
		Genito-Urinary
___	___	Bed Wetting
___	___	Blood/Pus in Urine
___	___	Frequent Urination
___	___	Can't Control Urine
___	___	Painful Urination
___	___	Prostate Trouble

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SOCIAL HISTORY

Does child take vitamin supplements?________ If so, please list:____
Does child consume caffeine?____ If so, how much per day:____
Does child exercise?__________ If yes, what is the frequency and type of exercise?________________________
____
Child's hobbies?____
What percentage of time during the day (at home or at school) does child spend:
lifting_____ sitting_____ bending______working at a computer_______

FAMILY HISTORY

Do you have any family members who suffer from the same condition you do? If so, please list:____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____ Cancer____ Mental Illness____
Diabetes ____ Asthma____ Heart Disease ____
Stroke ____ Kidney Disease____ Lung Disease____
Arthritis_____ Liver Disease ____
Other ____

TREATMENT GOALS

What are your goals for your child's care? (For example: long term condition resolution and pain/symptom-free living, short term pain relief, just an occasional adjustment or two when things flare up, etc.)
____
____
____
____
Previous Chiropractic Experience: Positive _________ Negative _________ Neutral _________ None __________

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case**:**
☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other ____

Name of Primary Insurance Company:____
Name of Secondary Insurance Company (if any):____
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:_________________________________ Date:________________

E-NEWSLETTER CONSENT

May we have permission to periodically email you Compass Chiropractic newsletters (An option to stop receiving newsletters will be on every email) ☐ Yes ☐ No

Compass Chiropractic

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SUMMARY

Date:__________________ **Patient Name:** ______________________ **Patient #**___________

1. What is child's major symptom? ____
2. What does this prevent child from doing or enjoying?____
3. If this is a recurrence, when was the first time you noticed this problem?___________________________

   How did it originally occur?____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? ____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only _____

   How long does it last? All Day _________ Few Hours ___________ Minutes ______________
5. Are there any other conditions or symptoms that may be related to child's major symptom?

   Yes _____ No _____. If yes, describe: ____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________________

   ____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other ____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _______________

   ____________________. If no, what have you tried to do that has not helped? ______________________

   ____
8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

   Lifting _____ Twisting _____ Walking _____ Other ____
9. List any major accidents you have had other than those that might be mentioned above: _____________

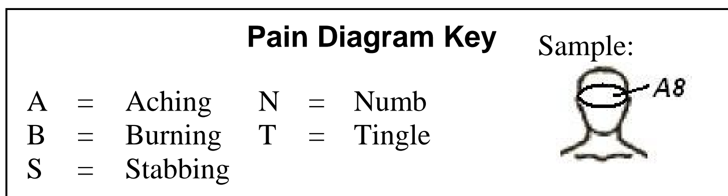
   ____

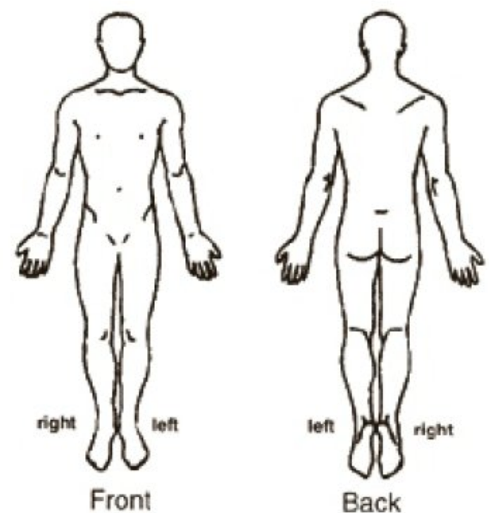
11. Please circle child's overall pain level below. On the right, label the areas of discomfort with a letter descriptor, and a number pain rating for each area like the sample.

Overall Pain Scale

Please circle the number that best describes your pain

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
NONE		LITTLE			MEDIUM				SEVERE	





Remarks: ____

____

Doctor's Signature ____ Date _____________