

CHILDREN'S INTAKE FORM

CHILD'S NAME: _____ AGE: _____

MOTHER/FATHER'S / GUARDIAN'S NAME: _____

DOB: _____ HEIGHT: _____ WEIGHT: _____

ADDRESS: _____

TEL. #: _____ EMAIL: _____

FAMILY PHYSICIAN: _____ TEL. #: _____

PLEASE LIST CHILD'S MAIN HEALTH CONCERNS:

PLEASE CIRCLE "C" IF YOUR CHILD HAS ANY OF THE FOLLOWING SYMPTOMS CURRENTLY, OR "P" FOR IN THE PAST:

Jaundice.....C P	Colic..... C P	Growth Delay..... C P
Growing pains.... C P	Hyperactivity.. C P	Lack of energy..... C P
Sleep problems...C P	Crying a lot.... C P	Learning problems.....C P
Nervousness.....C P	Tantrums..... C P	Hard to please..... C P
Bed wetting.....C P	Convulsions... C P	Breathing problems.... C P
Ear infections..... C P	Eczema/rash.. C P	Digestive upsets..... C P
Constipation..... C P	Diarrhea..... C P	Visual disturbances..... C P
Teeth problems.. C P	Parasites..... C P	Speech problems..... C P
Nail biting.....C P	Clinging.....C P	Teeth grinding..... C P

CHILDHOOD DISEASES:

Frequent colds....C P	Measles..... C P	Whooping cough..... C P
Chicken pox..... C P	Diphtheria..... C P	

PLEASE LIST ANY MAJOR INJURIES YOUR CHILD HAS HAD:

PLEASE LIST ANY HOSPITALIZATIONS OR OPERATIONS YOUR CHILD HAS HAD:

VACCINATIONS

APPROXIMATE DATE

Tetanus:	Yes	No	_____
Diphtheria:	Yes	No	_____
Chickenpox:	Yes	No	_____
Polio:	Yes	No	_____
Pertussis:	Yes	No	_____
Measles:	Yes	No	_____
Mumps:	Yes	No	_____
Hepatitis B:	Yes	No	_____
Other:	Yes	No	_____

BIRTH HISTORY:

Weight at birth: _____ Any birth complications? _____

Please circle if the delivery was: Normal Forceps delivery Premature Cesarean Difficult

Did any significant stressful events occur during pregnancy?

Emotional state during pregnancy:

Please circle if any of the following used during pregnancy:

Cigarettes Alcohol Drugs

PARENTAL DECLARATION AND CONSENT:

I, _____, mother/ father/ guardian (please circle) of _____, (child's name) hereby consent to treatment of the above named child by Salvatore Messina HD.. I understand and acknowledge that I have the option of seeking and or continuing medical treatments or services for the above mentioned child if I choose to do so.

Notification of any cancellation of appointments is required 24 hours in advance, otherwise full fee of missed appointment applies.

I agree to pay each fee in full at the end of each visit.

Parents'/Guardians' Signature: _____ Date: _____