



Ryan Coogan DC * 11902 97th Ave NE Kirkland, WA 98034 * 425-821-4600

Pediatric Intake Form

PERSONAL INFORMATION

Child's Full Name: _____ Date: _____

Parent's/Guardian's Names: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Date of Birth: ____/____/____ Age: ____ Gender: M F

Name of Pediatrician: _____ City: _____

PURPOSE OF CARE

Has your child been evaluated by a Chiropractor before today? ___ Y ___ N

Details: _____

Purpose of today's appointment:

___ Spinal health/nervous system evaluation

___ Specific health concern(s)

Please explain: _____

BIRTH HISTORY

Complications during pregnancy: Y N

Explain: _____

Complications during delivery: Y N

Explain: _____

Location of birth: ___ Home ___ Birthing Center ___ Hospital

Type of Delivery: ___ Vaginal ___ C-Section ___ Forceps ___ Vacuum Extraction

Other birth trauma: Y N

Explain: _____

Vaccinations according to the recommended schedule: Y N

Any adverse reactions to vaccinations: Y N

Explain: _____



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Breast Fed? Y N If yes, how long: _____

Formula Fed? Y N If yes, how long: _____

HEALTH HISTORY

Previous injuries necessitating medical care? Y N Explain: _____

Has your child been diagnosed with any medical problems or diseases? Y N Explain: _____

Has your child had any surgeries? Y N Explain: _____

Has your child been hospitalized? Y N Explain: _____

Currently taking any medications? Y N Explain: _____

Met all developmental milestones? (crawling, walking, etc.)? Y N

of antibiotic doses your child has taken: Past 6 months _____ Lifetime _____

Allergies/Intolerances: _____

Take supplements or vitamins? _____

Follow a special diet? _____

How would you describe your child's diet/nutrition?

multiple servings of fruits/vegetables daily high in sugar and processed food

Has your child experienced or been diagnosed with any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestion Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Lowered immune system (frequent colds, influenza) |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Extreme Fatigue |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Autism |

TRAUMA HISTORY

Has your child ever been involved in a car accident? Y N Explain: _____

Carry a backpack? Y N What Style? _____

Watch TV (hrs/day)? _____

Play computer/video games (hrs/day)? _____

Does your child get physical activity on a daily basis? Y N How much? _____



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Involved with any of the following sports? Gymnastics Soccer Football Martial Arts
Wrestling Basketball Cheerleading/Dance Baseball/Softball Volleyball Rugby
Skiing/Snowboarding

Other high impact or contact sports: _____

Did any of the following occur during your child's development?

- | | |
|---|---|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Fall from a tree |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Fall from bicycle |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Fall from playground equipment |
| <input type="checkbox"/> Sports accident | |

Other falls/accidents: _____

Is there anything else you would like us to know about your child? Y N

Explain: _____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Ryan Coogan and whomever he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

I acknowledge my responsibility for payment of the service from Dr. Ryan Coogan in accordance with his regular fees and terms. I accept financial responsibility for all services not covered by my insurance and authorize payment to be made directly to the doctor by my insurance company.

Printed Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date