



Paramount Chiropractic & Wellness
1201 Richardson Drive, Suite 130
Richardson, Tx 75080
T: 214-613-2989

Pediatric Intake Form

**Please fill out and email back to:
PCWgonstead@gmail.com**

Date: _____

Patient (child's) Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Parents: _____

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy.

Our goals:

To address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

If your child has no symptoms or complaints, and is here for wellness services, please check here.

Others need to briefly describe the chief area of complaint, including the effects it has on the child.

If he/she is experiencing pain, is it: Sharp Dull Comes and goes travels constant

Date of onset: _____ Onset was: sudden gradual associated with event

Since the problem started, it is: about the same getting better getting worse

What makes it worse: _____

What makes it better: _____

It interferes with: school sleep walking sitting hobbies other: _____

Prior occurrences or episodes:

Other doctors seen for this problem: _____

List any other health concerns the child may be dealing with that is different than the primary complaint:



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Birth and Delivery:

Duration of gestation: _____ weeks

Where was the baby born: Hospital Home Birthing center other: _____

Did you have a/an: Ob/Gyn Midwife Doula Other: _____

Was the birth assisted: yes no

If yes, how: Forceps vacuum extraction C-section Induced labor

How long was labor: _____ How long was delivery: _____

Was oxytocin/Pitocin used: Yes No Was epidural administered: Yes No

APGAR at birth: _____ APGAR after 5 min: _____ Birth weight: _____ Birth length: _____

Growth and Development

At what age did the child: Roll over: _____ Sit alone: _____ Teethe: _____

Crawl: _____ Walk: _____

*Consent of Parent or Guardian to care for child or minor within the scope of practice granted by the Governing bodies in the state of Texas.

Name of Parent or Guardian of child or minor:

Print Name: _____

Signature: _____ Date: _____