COWBOY SPINE
Performance Center

Gabriel W. Deal, D.C. M.S.
DrDeal@CowboySpine.com
CowboySpine.com
830-714-0006
830-714-0007

Pediatric Intake (0-5 years of age)

Patient information:

Date: ___________________

Child's Name: ____ DOB: ____________________________

Parent/Guardian's name: ____

Home Phone #: _______________________________ Cell Phone #: __________________________________

Address: ____

E-mail Address: ____

Pediatrician/Phone #: ____

Prenatal History:

Mother's health status prior and during pregnancy: ____

____

Maternal age for respective pregnancy: ____

How many pregnancies? _______________________ How many live births?_________________________

Approximate weight gain during pregnancy: ____

Complications during pregnancy? Preeclampsia? Eclampsia? ______________________________________

____

Drug use during pregnancy (Rx, OTC, recreational, remedies): ____________________________________

____

Presence of in utero constraint? (Breech position, etc.) ____

____

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Natural History:

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Was your birth plan followed?: If not, give a brief description of what happened: ____________________

____

____

Provider: ☐ OBGYN ☐ Midwife ☐ Other: ______________________

Type of delivery: ☐ Vaginal ☐ Cesarean

Spontaneous or induced labor (Pitocin): ____

Epidural administered (yes/no): ___________ Length of labor: _________________________

Instrument used: ☐ Vacuum Extraction ☐ Forceps ☐ None

Was an External Cephalic Version (ECV) performed? ☐ Yes ☐ No

Mother's birth position: ☐ On back ☐ Squatting ☐ Other: ____________________

Gestational age: ☐ Full term 37-42 weeks ☐ Premature <36 weeks ☐ Post term >42 weeks

Is there anything else you would like me to know about your pregnancy and labor/delivery?

____

____

History:

Did you breastfeed your child? ☐ Yes How long? _________ ☐ No ☐ Currently am

Has your child had any surgeries? ☐ Yes ☐ No

If yes, please list what kind of surgeries and how old they were:

____

Has your child ever been on antibiotics? ☐ Yes ☐ No

If yes, how often and what for? ____

____

Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list them: ____

____

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Is your child currently taking any vitamins? ☐ Yes ☐ No

If yes, please list them: ____

____

Is your child currently teething: ☐ Yes ☐ No

Has your child been vaccinated?: ☐ Yes ☐ No

Is your child currently experiencing any of the following?:

☐ Colic ☐ Recurrent ear infections ☐ Incoordination while walking

☐ Bedwetting ☐ Constipation ☐ Diarrhea

☐ Sleep disturbances ☐ Difficulty crawling ☐ Learning difficulties/Hyperactivity

☐ Asthma ☐ Allergies ☐ Other: ____________________

What brings your child to the office today?

____

When did it start?

____

Does anything make it better? ☐ Yes ☐ No If yes, please describe: ______________________________

____

How long does it last? ☐ All day ☐ Few hours ☐ Minutes

How frequent? ☐ Constant ☐ Intermittent ☐ Night only ☐ During certain activities

Describe the pain (if any):

☐ Sharp ☐ Dull/achey ☐ Stabbing ☐ Shooting ☐ Tingling ☐ Other: ______________

Does it travel anywhere?

____

Are there any other symptoms that your child is currently experiencing that may or may not be related to the above condition? ____

____

Doctor signature: ___________________________________ Date: _____________________________

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CONSENT TO TREATMENT OF MINOR

Patient's name: ____

Parent/guardian: ____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Olsen or Dr. Deal or other licensed doctors of chiropractic who now or in the future work at Cowboy Spine & Performance Center.

I've had an opportunity to discuss with the doctor of chiropractic named below and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Parent/Guardian Signature: ____________________________________ Date: ______________________

Employee Signature: ____ Date: ______________________