THE WELLNESS STUDIO
FAMILY CHIROPRACTIC & WELLNESS CARE

CST Pediatric Intake Form

Baby/Child's Name:_____ Date:_____

Parent or guardian's name: _____

Address: _____ Postal Code _____

Email Address: _____

Phone: (H) _____ (W) _____ (C) _____

Emergency Contact: _____

Birthdate: _____ Age: _____ Height/Weight: _____

Occupation: _____

Were you referred to this office? (Y/N) By Whom? _____

What is the reason for your visit?: _____

Has your baby had any previous treatment for this condition?: _____

What makes it better? _____ What makes it worse? _____

What other types of treatments are you currently receiving? (Chiropractic, Massage, Acupuncture, etc.)

_____

_____

Who is your family physician? _____

Are you seeing any specialists?_____

What medications is your child currently taking? _____

_____

Please list any major surgeries, injuries, or illness that you have experienced and when they occurred:

_____

_____

Please circle any of the following that concern or pertain to you:

Problems Breastfeeding ◯	Reflux ◯	Colic ◯	Not Sleeping ◯
Difficulty opening mouth ◯	Difficulty passing gas ◯	Difficulty with bowel movements ◯	Fussy, Hard to soothe ◯
Ear pain, tugging on ears ◯	Teething ◯	Overly sensitive, Quick to startle ◯	Doesn't like tummy time ◯
Favours turning their head to one side ◯	Favours one breast while breastfeeding ◯		

Is there anything about your baby's delivery or development that you would like us to know?

_____

_____

_____

_____

Is there anything else you would like us to know?

_____

_____

I understand that Massage Therapy and/or CranioSacral therapy are aids to health and it is my choice to receive treatment. I agree to communicate with my therapist any time I feel my well-being is compromised. I understand that Massage Therapy and/or CranioSacral Therapy are not substitutes for medical examinations or diagnosis and that it is recommended that I see a primary health care provider for that service. I have disclosed all existing medical conditions I am aware of and understand that it is my responsibility to update my therapist of any changes to my health status.

I also understand that the treatment fee will be charged for missed appointments unless 24 hours notice is given.

Date: _____

Client Name (Please Print): _____

Client's or Guardian's Signature: _____

Witness of Signature: _____