



POMAJZL Chiropractic

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Pediatric (Adolescent) Patient Intake

Patient Name: _____ Parent/Guardian Name: _____

Cell/Home Phone: _____ Work Phone: _____

Email address: _____ Sex: Male Female

Address: _____

How did you hear about us? _____

Birth Date: _____ Age: _____ Child SS#: _____

Height: _____ Weight: _____

Birth History

Delivery: Natural Vaginal Scheduled Cesarean Emergency Cesarean

Complications during delivery? If yes, explain: _____

Congenital Anomalies/Birth Defects: _____

Name of Obstetrician/Midwife/Family MD: _____

Date of last visit to MD: _____ Purpose: _____

Immunization History: On schedule Delayed schedule None

Has your child ever been treated on an emergency basis? If yes, please describe. _____

Present History (Purpose for the visit): _____

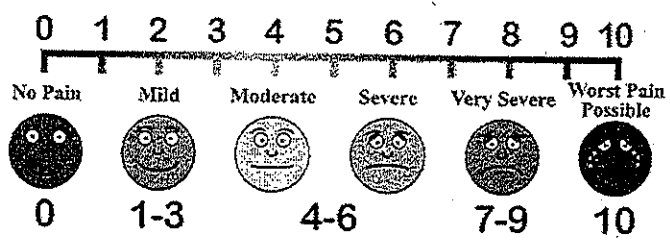
When did the condition first begin? _____ Onset? Suddenly Gradually

Has your child ever received care for this condition before? Yes No

Is this condition: Improving Getting worse Constant Intermittent
 Unsure

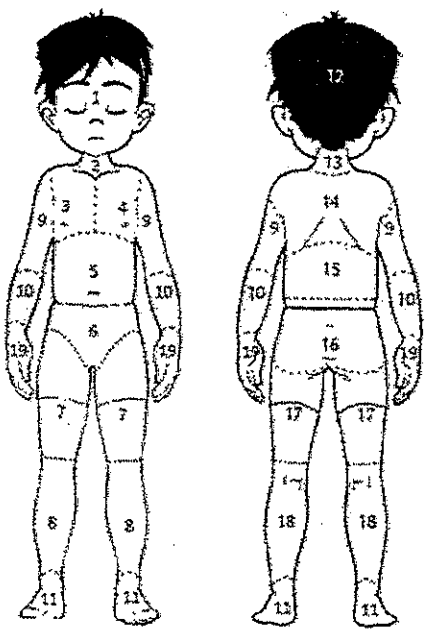
What makes the problem better? _____ worse? _____

Using the following scale, can you rate the pain/discomfort? (Please circle)



Using the following diagram, can you locate the area(s) of concern? (Please shade)

- 1 – face
- 2 – neck
- 3 – left chest
- 4 – right chest
- 5 – stomach
- 6 – abdomen
- 7 – thighs
- 8 – legs
- 9 – upper arms
- 10 – lower arms
- 11 – feet
- 12 – back of head
- 13 – back of neck
- 14 – upper back
- 15 – middle back
- 16 – lower back
- 17 – back thighs
- 18 – back legs
- 19 – hands



Review of Systems:

Please check if your child has had any of the following:

- Headaches
- Postural Imbalances
- Growing Pains
- Scoliosis
- Sensory Processing
- Asthma
- Torticollis
- Ear Infections
- Seizures
- Tonsillitis
- Sleep Problems
- Constipation
- Bedwetting
- Autism
- ADD/ADHD
- Frequent Fever
- Colic
- Learning Difficulties
- Acid Reflux
- Hip Dysplasia
- Allergies

