Sheehan Chiropractic
We help you get your head on straight

(https://www.laurasheehan.com)

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Profile Information — Step 1 of 3

You are completing the intake form: **Intake Form (Babies and Children)** for **

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential. Please fill out to the best of your ability. Some questions may only pertain to babies and some to children.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Preferred Name (if different)

Mobile Phone

Home Phone

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Country

United States

Street Address

Suite Number (i.e. Suite #100)

City

State

Postal / Zip

Date of Birth

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

How did you hear about us?

How did you hear about us?

Continue

Questionnaires — Step 2 of 3

You are completing the following intake forms: Intake Form (Babies and Children)

Intake Form (Babies and Children)

Medical Information

About Patient

Current Age:
Current Weight:
Current Height:

Has this condition

☐ gotten worse ☐ stayed constant ☐ comes and goes

Has this condition occurred before?

☐ Yes

☐ No

Allergies, if known (medical, environmental, foods)

Dietary Restrictions, if any (religious/vegetarian/vegan)

Number of anti-biotic treatments

Screening tests your child has had, if applicable

(e.g., blood, hearing, vision)

Current Medication(s) & dosage

(e.g., prescription, over-the-counter, vitamins, herbs, etc..)

Prescription, over-the-counter, vitamins

Past medication(s) & dosage

Past serious conditions, illnesses, injuries and/or hospitalizations & dates

Child's general state of health

Poor Fair Good Excellent

Other medical conditions?

Family and Health History Information

Family Health History - Has a close relative (parent, grandparent, sibling) has had any of the following

- [ ] Unknown (e.g., adoption, no record)
- [ ] Allergies
- [ ] Arthritis
- [ ] Asthma

- [ ] Cancer (if yes, please note type)
- [ ] Diabetes
- [ ] Eczema
- [ ] Kidney disease
- [ ] Skin disease
- [ ] Tuberculosis
- [ ] Other (Please describe)

Which, if any, of the following illnesses and to which intensity has your child had?

- [ ] Chicken Pox
- [ ] Ear Infections
- [ ] Impetigo
- [ ] Measles
- [ ] Mononucleosis
- [ ] Mumps

- [ ] Roseola
- [ ] Rubella
- [ ] Scarlet fever
- [ ] Strep throat
- [ ] Whooping cough

Immunization History

- [ ] MMR (mumps, measles, rubella)
- [ ] DPT (diphtheria, pertussis, tetanus)
- [ ] “Flu”
- [ ] Haemophilus influenza B
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Polio

- [ ] My child has not been immunized

Is there a history of adverse reaction(s) to immunization(s)?

- [ ] Yes
- [ ] No

If Yes, please describe the reaction

Prenatal Health of Parents

Health of Mother at conception

Unknown Poor Fair Good Excellent

Health of Mother during pregnancy

Unknown Poor Fair Good Excellent

Diet of Mother during Pregnancy (very generally)

- [ ] Breakfast
- [ ] Lunch
- [ ] Snacks
- [ ] Dinner
- [ ] Beverages (type and amount)

Were any of the following used by the Mother during pregnancy?

- [ ] Tobacco

- [ ] Alcohol

- [ ] Prescription drugs/medication(s)

- [ ] Over the counter drugs/medication(s)

- [ ] Supplement(s)

- [ ] Recreational drugs

- [ ] Other (Please describe)

Were any of the following experienced by the Mother during pregnancy?

- [ ] Bleeding

- [ ] Diabetes

- [ ] High blood pressure

- [ ] Nausea

- [ ] Thyroid problem

- [ ] Trauma, physical of emotional

☐ Vomiting

☐ Other (Please describe)

Did the Mother receive prenatal care?

☐ Yes

☐ No

☐ Unknown

Mother's age at child's birth?

Health of Father at conception

Unknown Poor Fair Good Excellent

Birth History

Premature: >30 weeks Premature: 31-35+ weeks Full term Late: +/- 2 weeks

Method of delivery

☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Vacuum ☐ Anesthesia

Were any of the following experienced by the child at or shortly after birth?

☐ Birth defect(s)

- [ ] Birth Injury
- [ ] Jaundice
- [ ] Rashes
- [ ] Seizures
- [ ] Other complications (Please describe)

Diet, Development and Environmental Information

Was the child breast fed? how long?

Formula? Which type? (e.g., milk, soy)

Foods introduced before 6 months, with month if known

Foods introduced at 6-12 months

Did your child ever experience colic? If yes, please describe severity

Dietary Restrictions, if any (religious/vegetarian/vegan)

Typical diet, generally

- [ ] Breakfast
- [ ] Lunch
- [ ] Dinner
- [ ] Snacks
- [ ] Beverages, type & amount

Health & Development

Child's health in the first year

Poor Fair Good Excellent

At what age did your child first, if known & applicable

- [ ] Sit up

- [ ] Walk

- [ ] Crawl

- [ ] Talk

Describe your child's sleeping patterns

Describe your child's temperament

Describe your child's behavior and performance at school (if applicable)

Environment

Child attends

- [ ] Home care

- [ ] Daycare

- [ ] School

- [ ] Home school

- [ ] other

Child's parents are

- [ ] Married

- [ ] Separated

- [ ] Divorced

- [ ] Other

If parents do not live in the same home, what is the living arrangement for the child?

Does the child exercise regularly?

N/A | Less than 1 hour | 1 hour or more | Very active

How much screen time does your child have per week?

N/A | Less than 1 hour | 1 hour to 4 hours | 4 hour to 8 hours | 8+ hours

Length of time that the child reads, or is read to per week

N/A | Less than 1 hour | 1 hour to 4 hours | 4+ hours

Does anyone in the child's household smoke?

☐ Yes ☐ No

Are there pets/animals in the home?

☐ Yes

☐ No

How is the child's home heated?

Are there toxins or other hazards the child is regularly exposed to?

How would you describe the emotional climate of the child's home?

Any other environmental factors, not covered?

Back Continue

Consents — Step 3 of 3

You are completing the following intake forms: Intake Form (Babies and Children)

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments

News and Special Promotions

- [ ] Yes, I would like to receive news and special promotions by email

Intake Form (Babies and Children) — Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] I agree – *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in Dr. Sheehan's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

- [ ] I am aware of the Cancellation Policy. – *Required*

Please check that all required questions have been answered.

Submit Intake Form

(https://jane.app)

Terms of Use (https://jane.app/terms) Privacy Policy (https://jane.app/privacy)