INFANT PATIENT INTAKE

Child's Name:	Date of Birth:	Date:
Male/Female:	Age:	
Address:	City:	State:	Zip:
Primary Phone #:	Accept Text: Yes / No	
Alternate Phone #:	Email:	

FAMILY INFORMATION

Mother's Name: DOB: / /	Father's Name: DOB: / /
Does one or both parents have custody:	Parents Marital Status: Married/ Single / Divorced/ Widowed
List ages of other children in the family:	
Emergency Contact: Relationship:	Phone #:
Whom may we thank for referring you:	

PRESENT HEALTH CONCERNS

What is the purpose for your child's visit: Crisis Management / Early Detection of problems / Prevention / Wellness /Maximizing brain growth and Development Other: _________________

Has you child ever received Chiropractic care before:

Has your child ever seen any other health care providers for this condition? Yes / No If yes, Whom? ___________________ When? ______________________

What are your child's interests?

YOUR CHILD'S SYMPTOMS

	Current	In Past		Current	In Past
Low Back Pain			Irritability		
Neck Pain			Hyperactivity		
Digestive Troubles			Bloody noses		
Asthma			Meningitis		
Headaches			Diarrhea		
Allergies			Constipation		
Sleeping disorders			Bed wetting		
Cold/Flu			Rashes		
Ear/Throat Infections			Milk/lactose Intolerance		
Breathing problems			Sinus problems		
Learning Disorders			Fatigue		
Other: ________________					

BIRTH HISTORY

Where was your child's birth: Birthing Center / Home / Hospital / Other:__________________

What was your child's gestational age at birth: ________ Weeks

Was the birth vaginal: Yes / No Was the birth assisted: Yes / No If yes, How? Forceps Vacuum Planned C-Section Emergency C-Section Induced Labor Assisted Head turn

Was there any: Fetal Distress / Meconium Staining / Head Presentation / Face Presentation / Breech
Was Labor: Spontaneous / Induced

Were medications or epidurals given to the mother during birth? Yes No

Duration of Labor: _________________ Duration of Pushing stage: ______________________

Was the delivery normal: Yes/ No If no: what complications were there?

Did your child spend any time in intensive care? Yes / No If yes, how long?

APGAR at birth: _____/10 APGAR at 5 minutes: _____/10 Birth weight: ___________ Birth Length: ______

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Were any medications give to your baby at birth? (Antibiotics, etc.) Yes / No If yes, which ones?____
GROWTH AND DEVELOPMENT
Was your child alert and responsive within 12 hours of delivery? Yes No If no, explain: ____
At what age did you child: Hold up head: ____________ Cut 1st tooth: ______________ Walk (11-15 months:_______________ Sit unassisted (5-7 months) __________________ Crawl: (8-10 months)___________
Do you feel that your child is developing as they should compared to other children of the same age? Yes / No
Do you have any concerns about you child's: Hearing Vision Balance Co-ordination Head Shape Other: __________________
Do his/her sleep patterns seem normal? Yes / No How many hours per day? ________________
How would you rate his /her quality of sleep? Excellent Good Fair Poor
What position does your child sleep in? Back Side Front
Do the child's siblings have any health concerns? Yes / No If yes, please describe: ________________________
EMOTIONAL STRESSORS
THE FOLLOWING INFORMATION IS EXTREMELY IMPORTANT BECAUSE MANY OF THE HEALTH CONCERNS THAT CHIROPRACTORS WORK WITH STEM FROM LIFESTYLE STRESSORS
Was the mother stressed during pregnancy: Yes / No Explain: _________________________________
Did the child's mother have any difficulties breastfeeding? Yes / No
Did the child's mother and child have any difficulty bonding? Yes / No
Does your child have any behavior issues? Yes / No If yes, what? ____________________________________
Does your child have difficulty sleeping (i.e. nightmares, sleepwalking, insomnia) Yes / No Please Explain: ____
Does your child attend day care? Yes / No If yes, from what age? ________________
Average time spent at computer/ watching T.V./playing IPAD/Smart phone, etc. each week: _____________Hours
Is your child nervous or has anyone suggested that your child was nervous? Yes / No
Do you feel like your child's social and emotional development is normal for their age? Yes / No
Rate your child's level of stress (Stress may be brought on by factors such as moving house/school, divorce, losing a family member) Low 1 2 3 4 5 6 7 8 9 10 High
CHEMICAL STRESSORS
During the pregnancy, did the mother: Smoke: Yes / No Drink Alcohol: Yes / No
Take Vitamins/supplements: Yes / No If yes, what? ___________________________________
Take recreational drugs? Yes / No If yes, what? _______________________________________
Become ill? (i.e. flu, gastro, preeclampsia) Yes / No If yes, what? ______________________________
Take medications? (i.e. Panadol, antibiotics, prescription medications) Yes / No If yes, what? ____
Receive ultrasounds? Yes / No If yes, how many? ___________________________________
Undergo Investigations (i.e. amniocentesis, CVS)? Yes / No
Was the child breast fed? Yes / No If yes, how long? ___________________________________
At what age was: Formula introduced? __________________ Brand: ________________ Breast fed only ______ Solid food introduced? _________________________ Cow's milk introduced? ________________________
Does the child have any food allergies? Yes / No If yes, to what? ____________________________________
What does your child like to eat/ favorite food?
What does your child regularly drink?

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How often does your child receive: processed foods, white sugar, gluten (wheat) and dairy in their diet? On special occasion On weekends A few times per week Daily Almost Every meal Never
Are you aware of the impact of food/nutrition on your child's behavior? Yes / No Comment: _____________
Rate your child's diet: Poor Good Excellent
Did you choose to vaccinate your child? Yes / No If yes: Full Schedule Reduced Schedule Homeopathic Vaccines
Did you notice any changes in your child after vaccinations? Yes No If yes, what? Fever Inconsolable crying Irritability Lethargy/Fatigue Arching Drowsiness Bowell Disturbances Feeding Disturbances Other: _________________
How many courses of antibiotics has your child received in their lifetime? ____________
When was the last course taken and why?
Any other chemical (medications) in the last 6 months?
Are there any pets at home? Yes / No Any smokers at home? Yes / No
PHYSICAL STRESSORS
Were there any traumas to the mother during pregnancy? (i.e. fall, accidents) Yes / No If yes, please explain:
Has your child had any falls (from a height) since birth? (i.e. changing table, couch, bed) Yes / No If yes, please explain:
Any traumas resulting in bruises, cuts, stitches, or fractures? Yes / No
Does your child have difficulty with co-ordination?
If you could improve one aspect of your child's health or behavior, what would it be?
FINANCIAL INFORMATION
Who is responsible for the account?
Is condition due to an accident: Yes / No Type of accident: Auto / Work / Home / Other
To whom have you made a report of your accident?
Name of Primary Insurance:
Policy Holder Name Policy Holder DOB: Relationship:
Name of Secondary Insurance:
Policy Holder Name: Policy Holder DOB: Relationship:
There are many concerns about the safety of procedures we undergo routinely, the environment we live in and the food we consumer to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Active Family Chiropractic will enhance your experience. Most people will experience some level of discomfort in the early stages of care. This is dues to the change in the pattern of the nervous system. It is a normal response during the initial phase of care. There are always risks associated with a therapeutic intervention. Regarding manual spinal adjustment, the risk of permanent injury or death is approximately 1 in 5,600,600. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for aches and pains is approximately 3 in 1,000. Statistically there is more chance of being hit by lightning than experiencing permanent damage or dying from a manual adjustment. We must explain these risks to you so that you can make an informed decision about commencing or continuing your care. If you have further concerns please ask your chiropractor. The adjustments and care you receive here at Active Family Chiropractic will be tailored to your child's specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. The range of techniques used provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner. Being a parent or legal guardian of this child, I have read the above, I hereby authorize Dr. Stephanie Hoglund to examine and administer care to my son/daughter as the doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.
Signature of Guardian: Date:
Guardian Name (Printed):