



Infant/Child Intake Form

Today's Date \_\_\_/\_\_\_/\_\_\_

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Patient Name First MI Last S/S - -

Guardian/Parent Name First MI Last S/S - -

Address City State Zip

Home Phone Work Phone Cell Phone

Birth Date Height Weight Sex: Female Male

Emergency contact Phone:

Your Employer Occupation

How did you hear about our office?

Health History:

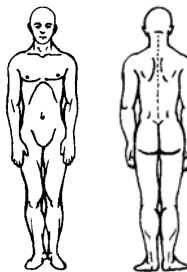
Have you (X) or a family member been diagnosed with any of the following conditions?

Heart Disease Cancer Diabetes High Blood Pressure Stroke Other

What are your primary health concerns for your child?

Does your child experience any of the following? (X any that apply)

- uncontrolled crying colic
difficulty feeding difficulty turning head
difficulty crawling constipation
respiratory problems frequent ear infections
sleeping problem digestive problems



Please indicate the area/s of complaint

Other:

How was the birthing process (vaginal/c-section) any complications, please explain

How long was labor?

When did you first notice these symptoms? Is the condition getting worse? No Yes

Have they had this problem before? No Yes When?

Have they had any falls, injuries or accidents? Describe

Have they ever been to a chiropractor before? No Yes How was your experience?

Currently taking the following medications for the following reasons:

Surgical History:

Pediatrician Name: Phone:

Guardian Signature: Date: