Infant and Child Intake Form

Thank you for taking the time to fully complete this form for your child. Please answer each question to the best of your ability knowing there may be numerous questions that you may not remember the answers to. For most questions please circle yes or no and give any explanation or pertinent information to any yes answers on the lines provided. Birth and Pregnancy history is vital to knowing the amount of stress on the nervous system of your child and that stress may play a pivotal role in risk factors for health conditions throughout your child's life.

Please bring completed form to the first appointment or they can be emailed to backtohealthwi@gmail.com

PATIENT INFORMATION:

Child's Name: _____ Nickname: _____ Date: _____
Sex:_____ Date of Birth:_____ Age:_____
Child's Address and Phone:_____
Who may we thank for referring you? _____

FAMILY INFORMATION:

Mother's Name: _____ Father's Name:_____
Address (if different from child:_____
Home or Cell Phone: _____ Work Phone: _____
Parents Marital Status: Married ____ Single ____ Divorced ____ Widowed ____
List ages of other children in family: _____

Why is your child beginning chiropractic care? _____
_____
_____

MOMS PREGNANCY HISTORY

What was the length of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:
Tobacco Y N
Alcohol Y N
Supplements Y N _____
Prescription Medications Y N_____
Over-the-counter meds Y N _____
Any vaccinations while pregnant Y N _____

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

Falls Y N _____
Motor Vehicle Accidents Y N _____
High Blood Pressure Y N _____
Diabetes Y N _____
Anemia Y N _____
Morning Sickness Y N _____
Indigestion Y N _____
Swollen Ankles Y N _____
Thyroid Problems Y N _____
Back Pain Y N _____
Abnormal Bleeding Y N _____
Were you Hospitalized Y N _____
Any Other Illnesses Y N _____

BIRTH HISTORY LABOR AND DELIVERY

Where was baby delivered? _____
How long was the labor from the first regular contractions to the birth? _____ hours
How long was the 2nd stage (the pushing phase) of the labor? _____ hours
Type of birth: Hospital Birth Home Birth Vaginal Delivery Planned C-Section Emergency C-Section
Interventions needed: Induction Forceps Delivery Vacuum Extraction
Fetal Distress _____
Fetal Position and Presentation _____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH: (If known)

Apgar Scores: At 1 minute _____/10 At 5 minutes _____/10
Baby's Crying Started: Immediately After Birth _____ Cried Strongly _____ Weak Cry _____
Did Not Cry for _____minutes
Baby's Color - Pink All Over _____ Blue Face _____ Blue Hand / Feet _____
Baby's Activity Arms and Legs Actively Moving _____ Floppy Baby _____
Intensive Care Was Required _____ Days in Neonatal Intensive Care Unit _____
Medication Given at Birth? _____
Vaccines Administered _____
Birth Weight _____lbs Birth Length _____ ins Baby Home on Day _____

INFANT HISTORY

<u>NUTRITION</u>:

Is/was your child breast fed? Y N If yes, for how long _____
Is/was your child formula fed? Which formula or other milk source? _____
What foods does your child eat on a regular basis? _____
_____
What is your child's favorite food? _____
Does your child have any feeding difficulties? _____
Does your child have any discomfort after eating? _____
Does your child have any food allergies or sensitivities? _____
Does your child have any persistent or intermittent skin rashes? _____
Is your child receiving any vitamin supplements? _____

TRAUMA:

Has your child had any falls or traumas? _____

Has your child ever fallen down stairs or fallen from any height? _____

Has your child ever been in a motor vehicle collision? _____

Has your child ever had a bone fracture or joint dislocation? (Where)_____

Has your child had any other trauma or injuries? (Describe)_____

Does your child ever bang his / her head repeatedly against a wall, bed or other object? Y N

GROWTH AND DEVELOPMENT:

Can your child sit unsupported? Y N Do you ever see your child sit in the W position Y N

At what age did your child:

sit-up? _____ months crawl? _____months walk? _____months

Does your child often trip and fall or is clumsy? Y N _____

Any delays in growth and development? Y N _____

Any usual movements or habits during infancy or childhood: _____

HEALTH HISTORY:

Has your child had colic? Y N _____

Has your child had any upper respiratory infections? Y N How often? _____

Has your child had asthma? Y N _____

Does your child ever complain of back or neck pain? Y N _____

Does your child ever complain of pains in the arms or legs? Y N_____

Does your child ever complain of headaches? Y N _____

Earaches? Y N Age of first earache? _____ How Many_____ Side: R L Both

Has your child had any other illnesses? Please list and date_____

_____

Is your child presently taking any medications? Y N _____

Has your child ever been to a hospital or emergency room for evaluation or treatment? Y N

_____

Any aggression, moodiness, anxiety or other mental and emotional stresses: Y N _____

_____

Do you have any other concerns about your child's health? _____

Any Other Important Info: _____

COVID

Have you ever had COVID or a + Test? _____ Estimated dates of infection: _____

Have you ever had a COVID vaccination or booster? _____ Dates of shots: _____

Any reactions to vaccinations: _____

Any residual COVID symptoms: _____

Financial Statement: Dr. English is out of network with all insurance companies and does not submit any billing to them. Patients are welcome to self-submit any charges or use any HSA or Flex cards to utilize your insurance benefits. Please let the doctor know if you would like to self-submit and you will then be sent the appropriate information to send to your insurance company on a monthly basis.

All payments shall be made at the time of the visit. Cash, Check or credit cards are excepted. Family discounts and prepaid single visit packages are available. Please ask for more information on these if you are interested. 24 hours' notice is needed to cancel any appointment without being charged for the missed visit. $25 for single visits, $50 for family visits and $100 for new patients that are missed.

Patient Signature: _____