PRECISION CHIROPRACTIC

INFANT(0-2y) CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION *all fields required*

First Name: _____ MI:_____ Last Name:_____

Name you go by:_____ Date of Birth: _____ Age:_____

Best Contact Information regarding appointments:

Parent/Guardian's Name:_____ Phone: _____

Email: _____ Preferred Appt reminders: TEXT CALL

Address: _____ City/Zip:_____

Who is responsible for this account?: Same as above Other: (list below)

Name: _____ Phone:_____

Address:_____ City/Zip:_____

Relationship to Patient: _____

PURPOSE OF VISIT

_____Post-Partum Evaluation --OR-- _____ Evaluation of the following symptoms (circle below)

Check ALL that apply:

_____ADD/ADHD
_____Autism
_____Anxiety
_____Headaches
_____Asthma
_____Ear Infections
_____Colds/Fevers
_____Torticollis
_____Accident/Injury
_____Scoliosis
Other:_____

For Post-Partum Evaluation only

What was the method of delivery?

_____Vaginal _____Planned C-Section _____Emergency C-Section _____VBAC
Other:_____

Complications during pregnancy/delivery? _____ No _____ Yes Explain:_____

Was/Is your child breast fed? _____ No _____Yes How Long? _____mos

Was/Is your child formula fed? _____ No _____Yes Formula Type? _____

< CONTINUE ON NEXT PAGE >

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HEALTH HISTORY

PLEASE CHECK ANY AND ALL PROBLEMS WITHIN THE LAST 2 YEARS:

_____Trouble Breastfeeding	_____Allergies	_____Asthma
_____Torticollis/Wry Neck	_____Digestive Disorder	_____Hyperactivity
_____Colds/Flu	_____Diarrhea	_____Broken Bones
_____Headaches	_____Bed Wetting	Other:_____
_____Behavioral Problems	_____Stomach Aches	
_____Excessive Crying	_____Constipation	

List Medications:

_____ _____ _____

_____ _____ _____

Studies show approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? _____No _____Yes

Has your child ever been involved in a car accident? _____No _____Yes

Has your child ever been seen on an emergency basis? _____No _____Yes Reason:_____

Other traumas not previously described? _____No _____Yes Explain: _____

RELEASE OF CARE

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office unless other arrangements have been made.

_____ _____

Infant Name Date

_____ _____

Parent/Guardian Name Printed Signature