

PATIENT INFORMATION *all fields required*

First Name: _____ Middle Initial: _____ Last Name: _____
Name you go by: _____ Date of Birth: _____ Age: _____ Gender: _____
Parent/Guardian's Name: _____ Relationship to Patient: _____
Phone: _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____

PATIENT CONDITION

Reason for Visit _____ OR Wellness Assessment (no current symptoms)
Is this due to an accident or injury? Yes No Type of Accident: Auto Home Other: _____

HEALTH HISTORY

Please check all that apply:

- | | | | | |
|---|---|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Torticollis | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Muscle Aches/Pains | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Eczema | <input type="checkbox"/> Constipation | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Asthma | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Reflux/Spitting Up | <input type="checkbox"/> Colic | <input type="checkbox"/> Other _____ | | |

List Medications:

Studies show approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, stairs, etc.) Was this the case for your child? ___ No ___ Yes
Has your child ever been to the emergency room? ___ No ___ Yes
Other traumas previously not described? ___ No ___ Yes

***Post-Partum Evaluation Only**

What was the method of delivery?

___ Vaginal ___ Planned C-Section ___ Emergency C-Section ___ VBAC

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

Was/Is your child breastfed? ___ No ___ Yes How Long? _____ mos

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

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 payments of all fees charged by this office unless other arrangements have been made.

Infant Name

Date

Parent/Guardian Name Printed

Signature