Welcome to our office!
Please complete the following…

Infant Intake

Personal and contact information:

Name: ______________________________ Parents/ Guardians: ____

Address: ____ City: _______ Prov ________ PC __________________

Phone: (H) ________________________ (C) _________________________

Email Address: ___________________________________ Referred By: ________________________________

Birth Date: ____________________ (Age _____) Sex: _____ Current Weight: ______lbs Height: __' __"/ ____cm

Chiropractic History:

Have you previously seen a chiropractor? □ Yes □ No Reason ____

Did they take x-rays? □ Yes □ No/NA

If yes, when was your last visit and how long did you receive care? ____

Main reason for today's visit: ____ □ Check up

Pain or problem started on ___________________

Why do *you* think it started? ____

Does anything make it worse? □ Yes □ No ____

Does anything make it better? □ Yes □ No ____

Is it worse during certain times of the day? ________________________

Is it progressively getting worse? □ Yes □ No Other Doctors seen: ____

Any home remedies? __________________________________

Patient History:

Neonatal History ____

Infancy History ____

Family History ____

Maternal History:

Age of mother ________ Previous pregnancies __________ Number of siblings __________

Health during pregnancy: □ Hypertension □ Proteinuria □ Infection □ Stress □ Other _____________________

Maternal medication/drug use Y □ N □ Type ______________________________ Exposure to x-ray Y □ N □

Birth History:

Length of gestation ________________________ Carried to term Y □ N □ Premature Y □ N □
Intervention during labour Y □ N □ Type: □ Forceps □ Ventouse suction □ Other
Medication during labour Y □ N □ Type: _____________________________________
Duration of labour ________________ Details of membrane rupture ____________________
Type of delivery ________________ Position of baby _______________________________
APGAR score ________________ Birth weight ____________ Birth Length ________________
Need for: Y □ N □ Respirator Y □ N □ Resuscitation Y □ N □ Suction
Length of hospital stay ______________ Admission into □ Special care nursery □ Intensive care
Postnatal intervention Y □ N □ Oxygen Y □ N □ Antibiotics Y □ N □ Phototherapy

Infant History:

Symmetrical movement – Hands Y □ N □ Arms Y □ N □ Legs Y □ N □
Hand preference – □ Left □ Right (if child is 12 months or older)
Head control ____

Sleep History:

Night:
Length of sleep __________________ How often wakes ________________ How well settles _______________
Day:
Length of sleep __________________ Easily disturbed Y □ N □ Restlessness Y □ N □

Feeding History:

Breast or bottle fed _______________ Difficulty latching Y □ N □ Fussiness Y □ N □
Sucking ability ___________________ Swallowing: □ Gagging □ Coughing □ Choking □ Dribbling
Average feeding time _____________ How often are feedings __________________________________
Reflux Y □ N □ Projectile vomiting Y □ N □ If yes, how often ___________________________
Name of formula (if using) ____

Systems Review:

Eyes – Sticky eyes Y □ N □ Conjunctivitis Y □ N □ Tracks face Y □ N □ Responds to smile Y □ N □
Nose – Snuffly breathing Y □ N □ Mucus Y □ N □
Ears – Infections Y □ N □ Responds to voice Y □ N □
Throat – Infections Y □ N □

Respiratory System:

Rattles Y □ N □ Wheezes Y □ N □ Vibrations Y □ N □ Other _____________________
Chest infections: Bronchiolitis Y □ N □ Coup Y □ N □ Pneumonia Y □ N □
Apnoea Y □ N □ Difficulty breathing Y □ N □

Gastrointestinal System:

Frequency of bowel movements ____
Difficulty with bowel movements Y □ N □ Diarrhoea Y □ N □ Hard stool Y □ N □
Tummy bloating Y □ N □ Gassy Y □ N □ Blood in stool Y □ N □

Skin:

Rashes Y □ N □ Spots Y □ N □ Marks Y □ N □ Bruises Y □ N □

Allergies: Y □ N □ Type ____
Genetic disorders: Y □ N □ Type ____
Health issue: Y □ N □ Type ____

Parent Signature ____________________________________ Date ____________________________