TAILOR MADE WELLNESS CLINIC

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www.tailormadewellness.com

CHIROPRACTIC

Infant Intake Form

(0 – 24 months)

Alberta Healthcare # (required for clinic paperwork purposes)	

Personal Information

Name		Date
Address		
City, Province		Postal Code
Home Phone.		OK to leave messages? ☐ Yes / ☐ No
Birth Date:	Gender:	
Age:	Birth weight:	Current Weight:

Emergency Contact Information

Mother's name:	
Home phone:	Work phone:
Father's name:	
Home phone:	Work phone:
Name of Pediatrician:	

Medications (Please list medication names where possible.)

☐ Antibiotics	☐ GERD medication	☐ Bronchodilators (Asthma)

Vitamins / Herbs / Supplements (Please list all.)	Allergies (Please list.)

Pregnancy / Labour / Delivery

Any problems during pregnancy? ☐ Yes / ☐ No			
Was pregnancy full term? ☐ Yes / ☐ No		If no, length?	
Place of birth:	☐ Hospital	☐ Home	☐ Other
Birth assisted by:	☐ Obstetrician	☐ Midwife	☐ G.P.
	☐ Other		
Manner of birth:	☐ Normal vaginal	☐ Forceps assisted	☐ Suction assisted
	☐ Caesarean		
Labour was:	☐ Average	☐ Easy	☐ Prolonged
	☐ Very rapid		
☐ Problems encountered during labour/delivery? (Please give details)			

Primary concern

What is your child's <u>primary concern</u> today?
Date of onset/duration?

TAILOR MADE WELLNESS CLINIC **Chiropractic Infant Intake Cont'd**

General Health History			
Was your child breast fed?	☐ Yes (How long?)/ ☐ No		
History of colic?	☐ Yes (When is crying most intense?)/ ☐ No		
Number hours sleep per night?	Time put down for night?		
Quality of sleep	☐ Good	☐ Fair	☐ Restless
	☐ Fussy		
How would you describe your child's health?	☐ Robust	☐ Poor	
	☐ Good	☐ Sickly	
	☐ Average		
Are bowel movements regular?	☐ Yes / ☐ No (Details:)		
Any of the following concerns?	☐ Recurring ear infections	☐ Restlessness	
	☐ Recurring throat infections	☐ Sluggishness	
	☐ Digestive problems	☐ Coordination problems	
	☐ Eye focus skills	☐ Late walking	
	☐ Grasping skills	☐ Late talking/communication	
Approximate age of first crawling? Walking?			
Did your child have any prior health problems that have been corrected or outgrown? ☐ Yes / ☐ No If yes, please explain:			
Has your child ever been treated by a Chiropractor for any condition? ☐ Yes (When?) / ☐ No			
If yes, Doctor's name: Were treatments helpful? ☐ Yes / ☐ No			
Have you ever lost an infant to Sudden Infant Death Syndrome (SIDS)? ☐ No / ☐ Yes			
Signature			
Parent/Guardian signature:			