Infant Intake

Information contained within this form is considered strictly confidential. Your responses are essential to help us better understand your Baby's complete health history, goals of treatment and to ensure the delivery of the best possible care, support and necessary referrals. This form must be completed in full before we can begin treatment.

Given Name: _____ Nickname: _____
Sex at Birth: _____ Pronouns: _____
Street Address: _____ Date of Birth: _____
City: _____ State: _____ Age: _____
Zip: _____ Pediatrician: _____

Who lives with you (list names, ages & relationship to child)?
_____
_____
_____

How do you prefer to be contacted by our office? [ ] phone [ ] text [ ]email
May we leave voicemails about your appointments? [ ] yes [ ] no
How did you hear about our office? _____

Emergency Contact:
Full Name: _____ Pronouns: _____
Relationship to Child: _____ Cell Phone: _____

Insurance Information
Insurance Company: _____ ID Number: _____
Name of Policy Holder: _____ Group Number: _____ [ ] n/a
Relationship to Policy Holder: [ ] child [ ] self Policy Holder Date of Birth: _____

Who is responsible for your child's bill? _____
[ ] I understand Medicaid and Child Health Plus do not cover Chiropractic care in New York State
[ ] I acknowledge that it is my responsibility to understand my Childs health insurance benefits

Please list any other providers you are working with in addition to your pediatrician:
Lactation Consultant: _____ Feeding Therapist: _____
Physical Therapist: _____ Occupational Therapist: _____
Speech Therapist: _____ Cranialsacral Therapist: _____
Pediatric Dentist: _____ ENT: _____
Other Specialists: _____
_____
_____

Describe the reason for your infant's visit today:
_____
_____
_____

Please list any specific treatment goals you may have for care in our office:
1. _____
2. _____
3. _____

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Birth History
born at _____ weeks gestation total length of labor _____ pushing: _____hours/min

[ ] vaginal [ ] planned cesarean [ ] unplanned cesarean [ ] NICU _____days/weeks

[ ] induced _____ weeks [ ] forceps delivery [ ] vacuum assisted delivery

[ ] planned hospital birth [ ] planned home/birth center birth. [ ] unplanned hospital transfer

complications during/following birth: _____
_____

Prenatal History
Please list any health concerns, conditions or significant finding that occurred in utero (example: twins, breech presentation, polyhydroamnios etc.): _____
_____
_____

Health History
Please list any conditions your child has been diagnosed with and the name of the medical provider who diagnosed them: _____
_____
_____

Surgeries and/or hospitalizations (list dates, reasons, and any complications): _____
_____
_____

Please list any significant family history for your immediate family (parents/siblings): _____
_____
_____

Is Baby gaining weight as expected? _____

Do you notice any postural asymmetries in your Baby (ex. preferred head position, only moves one arm… etc)?
_____
_____
_____

Does your Baby experience any of the following symptoms:

[ ] colic/excessive irritability
[ ] poor weight gain
[ ] coughing, choking or gulping during feeds
[ ] difficulty latching
[ ] excessive drooling
[ ] difficulty passing gas
[ ] tight firm belly
[ ] reflux
[ ] sliding/popping off breast
[ ] only sleeping while held upright
[ ] waking up congested
[ ] torticollis
[ ] plagiocephaly
[ ] constipation
[ ] short sleep cycles
[ ] snoring/loud breathing
[ ] mouth breathing
[ ] frequent hiccups
[ ] clicking noise while sucking
[ ] milk leaking out sides of mouth
[ ] unable to keep pacifier in mouth
[ ] other: _____
_____
_____
_____

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Feeding History
Did Baby initiate breast/chest feeding at birth? [ ] yes [ ] no

How are you currently feeding your Baby? [ ] breastfeeding [ ] formula [ ] pumped breast milk in bottle

[ ] combination of breastfeeding and pumped breast milk [ ] combination of breastfeeding and formula feeding

If bottle feeding, what type of bottle(s) are you using? _____

Are you currently using a nipple shield, SNS system, syringe feeding etc…? _____
_____

Do you have any specific feeding goals for your baby: _____
_____
_____
_____

If breast/chest feeding, is the lactating parent experiencing any of the following symptoms:
[ ] creased, cracked or blanching of nipples
[ ] painful latching
[ ] mastitis
[ ] oversupply of breastmilk
[ ] difficulty bonding with Baby
[ ] plugged ducts
[ ] incomplete breast drainage
[ ] nipple thrush
[ ] gumming or chewing of nipples

Is there anything else about you, your child or your family that you would like me to know?
_____
_____
_____
_____
_____

Infant Informed Consent: please ask questions if anything is unclear

Parents seek chiropractic care for their infants for many reasons. The doctor will evaluate your child for areas of the body holding tension, asymmetrical movement patterns, limited range of motion, proper joint function, infant feeding skills and cranial nerve function. If indicated, the doctor will treat your child using a combination of infant specific chiropractic adjustments, gentle stretching, cranial nerve exercises and rehabilitative exercises. Infant chiropractic adjustments are extremely gentle, using no more than 4 grams of pressure during treatment. Side effects of treatment are rare and may include temporary increased fussiness, increased bowel movements, increased sleepiness or increased alertness. These side affects are rare; however, when present, last about 12-24 hours. If during the course of care we encounter non-chiropractic or unusual findings we will advise you of those findings and recommend that you seek the services of another health care provider.

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed consent and herby grant permission for my child to receive chiropractic care.

_____ _____
(parent/legal guardian signature) (date)