Infant New Patient Form

CONFIDENTIAL PATIENT INFORMATION

Welcome to Optimal Health Chiropractic! Please complete all questions and PRINT clearly. Date: …… / …… / ……

Baby's Surname:	Baby's First Name:
Address:	Town:
	Post code:
Home Phone:	Mobile Phone:
Birth Date: / /	Email:
Mother's Name:	Father's Name:
Brother's or Sister's Names:	
How did you hear about our practice?	

Please tick if your baby's reason for attending is to improve Health & Wellness: □ or

Please list your baby's complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____

Is the problem getting: □ Progressively worse □ Progressively better □ Staying the same □ Comes & goes

What aggravates the condition?_____

What relieves the condition?_____

What do you think is wrong? _____

What do you think caused the problem? _____

Do your baby's parents or siblings have similar problems? □ Yes □ No If yes, who: _____

Please tick if your baby has had any of the following:

□ Feeding difficulties	□ Low energy	□ Allergies	□ Heart disease
□ Reflux	□ Irritability	□ Frequent colds / infections	□ Diabetes
□ Difficult to wind	□ Worse at night	□ Fevers	□ Cancer
□ Bladder problems	□ Pulling legs up	□ Seizures / fainting	□ Asthma
□ Digestive problems	□ Constant crying	□ Cold hands / feet	□ Eczema

Please list the practitioners who were consulted for these conditions:

1. _____ Diagnosis given: _____
2. _____ Diagnosis given: _____

What is your baby's sleeping pattern? _____

What is your baby's feeding pattern? _____

How is your baby fed? □ Breastfed □ Bottle fed □ Both Name of Formula?_____

Did you suffer from any maternal illness during the pregnancy? □ Yes □ No If yes, what: _____

How many ultrasounds did you have during the pregnancy? _____

What was your child's birth like_____

How long entire labour?_____ How long did you actually push?_____

Was the birth:

□ Premature □ Due Date □ Overdue □ Induced □ Planned Caesarian □ Emergency Caesarian

□ Baby's head was pulled □ Forceps □ Ventouse □ Breech □ Face / forehead presentation

Did your baby have any: □ Bruising □ Jaundice □ Special care, if yes, what: _____

Please list any operations your baby has had:

1. _____ 2. _____ 3. _____

Please list any serious illnesses your baby has had:

1. _____ 2. _____ 3. _____

Please list any traumas, accidents, or injuries your baby has had:

1. _____ 2. _____ 3. _____

Is your baby currently on any medication? If yes, what type and what for?

_____

Has your baby had any of the following vaccinations? □ DPT □ MMR □ Polio □ TB □ Meningitis

Did your baby have any reactions to any of those vaccines? □ Yes □ No If yes, specify: _____

Name and address of your baby's GP:_____

Has your baby ever been to a chiropractor before? □ Yes □ No If yes, when? _____

Has any blood relative of your baby had any of the following. If yes, please specify (who, what, when):

□ Bone or Joint disease (Arthritis / Osteoporosis) _____

□ Vascular disease (Heart disease / Stroke / Blood Pressure) _____

□ Cancer (Benign / Malignant) _____

□ Respiratory problems (Lung / Chest / Asthma) _____

□ Digestive problems (Stomach / Bowel) _____

□ Reproductive system problems _____

□ Diabetes / Metabolic disorders _____

□ Epilepsy / Nervous system disorders _____

□ Skin disorders _____

□ Allergies _____

□ Other _____

DECLARATION: This information is accurate to the best of my knowledge.

PARENT SIGNATURE: …… DATE:…… / …… / ……

DOCTOR SIGNATURE: …… DATE: …… / …… / ……