MEADOWOOD FAMILY CHIROPRACTIC

www.meadowoodchiropractic.com | 10-1549 St. Mary's Road, Winnipeg MB R2M 5G9 | (204) 255-6666

INFANT INTAKE FORM

PATIENT INFORMATION

Date (D/M/Y): _____

Child's Name: (Surname) _____ (First Name) _____ Date of Birth (D/M/Y): _____

Mother's full Name: _____ Father's full Name: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Alternative Phone Number: _____

Email Address: _____

MB Health Number (6 digit): _____ PHIN (9 digits): _____

Has your child received chiropractic care before? Y / N If yes, how long ago? _____

Were you pleased with his/her care? Y / N

Child's Age: _____ Weight: _____ Height: _____

Who can we thank for referring you to our office? _____

The human body is designed to express health and function normally. However, events may occur in life which can ***interfere*** *with this natural ability. This interference is most commonly caused by* ***vertebral subluxations****, resulting from* ***physical, chemical, or emotional stress.***

Chiropractic *aims to locate and correct/reduce the vertebral subluxation and nerve interference.*

Current Health Condition

What is the primary reason and/or health concern for your visit today?

_____

_____

When/how did the current complaint occur: _____

Is this complaint (circle one): New / Recurring Did it come on (circle one): Suddenly / Gradually / Comes & goes

What makes it better? _____ What makes it worse? _____

Did a fall, injury or trauma contribute to the current complaint: _____

Have you sought help from other practitioners for this concern? Y N

If yes, please explain: _____

Is your child presently taking medication/or under any other medical care? _____

If yes, for what conditions? _____

Birth History:

Length of Pregnancy: Full Term (weeks) _____ / Early (# weeks): _____ / Late (# weeks): _____

Any issues during pregnancy for Mom/Baby: (position of baby, blood pressure, etc.):

_____

_____

Type of delivery (please circle one): Vaginal / Caesarean / Assisted (Vacuum, Forceps)

Baby position prior to birth: Head down / Transverse / Breech / Posterior

Pain Medication or Other Procedures: Epidural / Induction / Pitocin / (other): _____

Length of labour: _____ Would you say your delivery was difficult (circle one)? Yes / No

Birth Weight: _____ Birth Length: _____ Congenital Anomalies: _____

Infant History

Latching Well (circle one): Yes / No Breast Preference: Yes / No If Yes: Left / Right

Feeding (circle one): Breast / Bottle / Formula

Sleep Quality: Good / Fair / Poor Average Hours of sleep per night: _____ Average hours in a row: _____

Trouble falling asleep (circle one): Always / Occasional / Never

General Health History

Any known Health conditions / allergies: _____

Illness/ Injuries: _____

Hospitalizations / Surgeries / Stitches / X-rays: _____

Last Doctor's Appointment: _____ Concerns: _____

Treatment for any health conditions in the past year:

_____

Please circle any of the following conditions your child is currently experiencing and underline any that were a problem in the past:

Colic	Screaming/crying	Fussing in specific position
Tilting head to one side	Slow weight gain	Difficulty nursing
Constipation/diarrhea	Anemia	Skin eruptions/eczema
Flattened cranium	Acid Reflux	Difficulty breathing
Difficulty holding head up	Difficulty rolling over	Difficulty crawling or walking

Other Concerns:

Please check the boxes that mostly describes your current goals for your child's health/well-being:

☐ *I am mainly concerned about relief of a particular symptom*

☐ *I am mainly concerned about relief of a symptom and preventing its return*

☐ *I want optimum health and well-being on every level available to my child*