250-462-4776
#166-290 Riverside Dr.
Penticton, BC, V2Y 5Y5
www.nuvistachiropractic.com

INFANT AND PEDIATRIC INTAKE FORM

Name: ______________________________ **Phone:** (home) _______________________

Mother and Father's Name: ____

Birthdate: ____________________(month/day/year) (cell) _________________________

Address: ______________________________ **Email:** ______________________________

_______________________________________ I would like: ☐ email reminders
☐ text message reminders
Postal Code: ___________________________ ☐ phone call reminders

How did you hear about us? ☐ Friend: _________________ ☐ Doctor: _______________

☐ Other professional: ____________________________ ☐ Website ☐ Facebook

☐ Other: ____

CURRENT CONDITION:

What brings you into the office today? ____

____

When did it start? ____

List any other professionals seen for this: ____

Any other concerns or issues we should be aware of? _____________________________

____

HEALTH HISTORY AND INFORMATION:

PREGNANCY:
Were there any complications during your pregnancy? Yes / No (describe) _____________

____

Was your child born: ☐ in hospital ☐at home ☐ vaginally ☐ C-section

Did you experience any of the following during your pregnancy:

□ falls □ MVA □ high blood pressure □ diabetes □ anemia □ seizures

□ heart problems □ pain or other complaints □ abnormal bleeding

□ hospitalizations □ any other illness or concerns

Describe: ____

BIRTH:

How many hours of labour: ___________ Drugs during delivery: Yes / No ____________

Birth details:

Did you experience any complications during the delivery: _________________________

Do you feel the birth was traumatic for your child? Yes / No (describe) _______________

____

Birth weight: ____________ Any emergency care needed? _________________________

Medications given at birth? ____

Baby's APGAR score? _________ Was your child's head misshapen at birth? Yes / No

Any other complications or concerns? □ Yes □ No (describe) ______________________

FEEDING AND DIGESTION:

Baby's Feeding Habits: □ breastfed (how long? _____ months) □ bottle

□ formula (how long? _____ months) (type: _______________)

Any difficulties latching? □ Yes □ No (describe) __________________________________

Have you introduced solids? □ Yes □ No (describe) ______________________________

____

Does your baby seem to prefer one breast over the other? □ Yes □ No

Does your baby seem to prefer turning his/her head one way over the other? □ Yes □ No

Do you find breastfeeding especially painful? □ Yes □ No

Does your child spit up after eating? ☐ Yes ☐ No (describe) ________________________

Does your child hiccup often? ☐ Yes ☐ No (describe) ______________________________

Do you feel that your child has excessive gas/digestion issues? ☐ Yes ☐ No

(Describe) ____

How often does your child have a bowel movement? _______________________________

Does your child currently, or have they ever suffered from constipation or diarrhoea?

☐ Yes ☐ No (describe) ____

Is your child currently taking? ☐ probiotics ☐ other supplementation ______________

☐ any other medication: ______________________________

Any allergies? ☐ Yes ☐ No (describe) ____

SLEEP HABITS:

How would you describe your child's sleep habits? _________________________________

____

Are your child's sleep habits currently working for your family? ☐ Yes ☐ No

Does your child seem to have a preferred head position while sleeping? ☐ Yes ☐ No

OTHER:

Does your child cry often? ☐ Yes ☐ No (describe) _________________________________

Does your child suffer from colic? ☐ Yes ☐ No (describe) __________________________

Have they in the past? ☐ Yes ☐ No

If yes, would you consider it: Mild Moderate Severe

Has your child ever had an ear infection or any other infection? ☐ Yes ☐ No

(describe) ____

Has your child ever taken antibiotics? ☐ Yes ☐ No

When and for what reason? ____

Is your child currently:

☐ holding their head up ☐ turning head side to side ☐ rolling back-to-front

☐ rolling front-to-back ☐ sitting without support ☐ army crawling

☐ bringing objects to the mouth ☐ traditional crawling ☐ bum-scooting

☐ walking ☐ running ☐ jumping ☐ speaking basic words

What age did your child begin to crawl? _______months

How long did they crawl for? __________months

Is your child especially irritable during: ☐ tummy time ☐ diaper change

☐ in the car seat ☐ while driving ☐ while being rocked/swung, etc.

Has your child had any significant falls/accidents/injuries? ☐ Yes ☐ No (describe) _____

____

Has your child ever been in a motor vehicle accident? ☐ Yes ☐ No

Immunizations/Vaccinations? ____

Has your child had any diseases/illness? Yes / No _________________________________

Has your child ever been hospitalized or had surgery? Yes / No ______________________

Has your child ever broken any bones or had a serious injury? Yes / No _______________

Does your child have a history of seizures/concussion/stroke? Yes / No _______________

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and I give the clinic permission to leave messages regarding appointments at any of the contacts I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my benificial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Guardian Signature: ___________________________________ Date: _________________