ABUNDANTYOU
CHIROPRACTIC & WELLNESS CENTER

INFANT AND TODDLER CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child. It is a pleasure to welcome you to our chiropractic family.

Child's Name _____ DOB: ____/____/____ Age _____ Sex M__ F__

Height _____ Weight _____ # of Siblings _____ Parent Email _____

Name of Parents/ Guardians _____

Address_____ City _____ State_____ Zip _____

Mother's Cell #_____ Father's Cell # _____ How did you hear about our office? _____

IS THERE A SPECIFIC REASON FOR BRINGING YOUR CHILD IN?

__No. I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

__Yes Reason(s) for seeking care _____

Other providers seen for this condition Yes __ No__ If yes, provider name(s) and prior treatment:

_____

OTHER HEALTH PROBLEMS

Please check any current or past problems your child has had on the list below:

__Breastfeeding Issues	__Allergies	__ADHD	__Broken Bones
__Poor/Shallow Latch	__Asthma	__Autism	__Sprains/Strains
__Clicking w/ Feeding	__Sinus Infections	__Hyperactivity	__Fainting
__Pain w/ Nursing	__Rashes/Hives	__Behavioral	__Hernias
__Restless Sleep	__Runny Nose	__Scoliosis	__Arm/Elbow Pain
__Colic	__Itchy Eyes	__Joint Pain	__Headaches
__Reflux	__Cough/Wheeze	__Growing Pains	__Neck Pain
__Car seat Discomfort	__Gassiness	__Night Terrors	__Back Pain
__Excessive Crying	__Constipation	__Bed Wetting	__Arm/Elbow Pain
__Weight Gain Issues	__Diarrhea	__Delayed Milestones	__Leg/Hip Pain
__Chronic Ear Infections	__Poor Appetite	__Seizures	__Knee/Foot Pain
__Frequent Sickness	__Stomach Aches	__Heart Condition	__Tip Toe Walking

Other Conditions Not Listed: _____

HEALTH HISTORY

Previous Chiropractor(s): _____ Reason for Care:_____

Name of Pediatrician: _____ Date of last visit: _____

Reason for visit: _____

Number of antibiotics taken in lifetime:_____ Condition(s) treated: _____

Medications and conditions being treated: _____

Has your child been injured in any type of accident (ie. Birth trauma, car accident, major fall, etc.)? Y__N__

If yes, please describe with dates:_____

Prior surgeries or hospitalizations? Y__N__ Type and Date: _____

Vaccination History: _____

PRENATAL HISTORY

Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____

Location of birth: Hospital _____ Home _____ Birth Center _____

Medications used during birth: None _____ Pitocin _____ Epidural _____

Interventions used during birth: Breaking of water ____ Vacuum _____ Forceps ____ Episiotomy _____

Position of baby at birth: Head down _____ Posterior _____ Breech or malpositioned _____

How long was your labor? _____ Cesarean: Y/N Planned _____ Emergency _____

Complications during pregnancy: Y__N__ If yes, Please describe_____

Complications during delivery: Y__N__ If yes, Please describe: _____

Did you have chiropractic care during your pregnancy? Y__N__

Genetic Disorder/Disability? Y__N__ If yes, Please describe: _____

How many weeks gestation was the baby at birth? _____ Birth weight _____ Birth length _____

Any NICU Stay? Y__N__ If yes, Please describe: _____

FEEDING HISTORY

Breast Fed: Y__N__ How long? _____

Formula Fed: Y__N__ How long? _____

Type of formula:_____

Introduced to solids at _____ months, Cow's milk at _____ months

Food/ juice allergies or intolerances: Y__N__ Please List: _____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night _____ Quality of sleep: Good__ Fair__ Poor__

Any developmental delays?	Respond to sound _____	Follow object with eyes _____
Hold head up _____	Crawl _____	Sit alone _____
Stand alone _____	Walk alone _____	Say words _____

GOALS FOR CARE

Please list your top 3 goals for your child's care in our office:

1._____

2._____

3._____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent or Guardian-Print Signature Date