

INFANT PATIENT INFORMATION

(Birth to 3)

CHILD’S NAME D.O.B.: SEX

MOTHER’S NAME FATHER’S NAME

ADDRESS CITY STATE ZIP

HOME PHONE ALTERNATE PHONE

FAMILY EMAIL:

PEDIATRICIAN/FAMILY MD/DO:

DATE OF LAST VISIT: PURPOSE:

NUMBER OF SIBLINGS AGES:

Who can we *Thank* for referring you to our office?

BIRTH WEIGHT: BIRTH LENGTH: CURRENT WEIGHT: CURRENT LENGTH:

THIRD TRIMESTER PRESENTATION: (CIRCLE) VERTEX, BREECH, TRANSVERSE, FACE/BROW DURATION OF GESTATION: WEEKS

TYPE OF BIRTH: (CIRCLE) NORMAL VAGINAL, CESAREAN, FORCEPS, SUCTION CUP/VACUUM LOCATION OF BIRTH: (CIRCLE) BIRTHING CENTER, HOSPITAL, HOME

WERE MEDICATIONS GIVEN TO MOTHER DURING LABOR/BIRTH: IF YES, WHAT?

PROBLEMS DURING PREGNANCY:

PROBLEMS DURING LABOR/DELIVERY:

APGAR SCORES: PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? CYANOSIS (BLUE)?

CONGENITAL ANOMALIES/DEFECTS? IF YES, PLEASE EXPLAIN

INFANT FEEDING: BREAST: HOW LONG? BOTTLE: AGE INTRODUCED

PREFERENCE FOR ONE SIDE WHILE FEEDING?

ANY CONCERNS WITH BOWEL/BLADDER HABITS? (APPEARANCE, FREQUENCY, ETC.)

HOURS SLEEPING PER NIGHT: QUALITY OF SLEEP: (CIRCLE) GOOD, FAIR, POOR

DESCRIBE ANY HEALTH PROBLEMS THAT EXIST ON THE MOTHER’S SIDE OF THE FAMILY:

THE FATHER’S SIDE:

ANY SIBLINGS WITH HEALTH PROBLEMS/CONCERNS, OR SCOLIOSIS?

### CHEMICAL STRESSORS:

DURING PREGNANCY, DID THE **MOTHER:**

SMOKE/USE TOBACCO: HOW MUCH: , DRINK ALCOHOL: HOW MUCH , USE DRUGS: TAKE SUPPLEMENTS/VITAMINS: LIST:

TAKE MEDICATIONS: LIST:

BECOME ILL: IF SO, HOW? , RECEIVE INVASIVE PROCEDURES:

DID YOUR CHILD RECEIVE VACCINATIONS?: IF YES, WHICH ONES?

DID YOUR CHILD HAVE ANY REACTIONS TO VACCINATIONS? DESCRIBE:

NUMBER OF DOSES OF ANTIBIOTICS TAKEN DURING PAST SIX MONTHS: LIFETIME:

CURRENT MEDICATIONS:

ANY PETS AT HOME?

ANY SMOKERS AT HOME? WHO, AND HOW MUCH?

### PSYCHOLOGICAL STRESSORS:

MOTHER HAVE DIFFICULTIES WITH LACTATION? ANY PROBLEMS BONDING?

DOES THE CHILD HAVE ANY BEHAVIOR PROBLEMS?

DOES THE CHILD HAVE DIFFICULITY SLEEPING (NIGHT TERRORS, SLEEP WALKING, ETC):

DOES YOUR CHILD GO TO DAYCARE? FROM WHAT AGE?

AVG. NUMBER OF HOURS TV/COMPUTER PER WEEK?

### TRAUMATIC STRESSORS:

ANY EVIDENCE OF TRAUMA DURING BIRTH? (CIRCLE) BRUISES, ODD SHAPED HEAD, STUCK IN BIRTH CANAL, RESPIRATORY DEPRESSION, CORD AROUND NECK, OTHER:

FAST OR EXCESSIVELY LONG BIRTH?

HAS THE CHILD HAD ANY MAJOR FALLS SINCE BIRTH? NEED STICHES OR CAUSE A FRACTURE?

ANY CAR ACCIDENTS? TYPE OF ACCIDENT? WAS ANYONE INJURED?

ANY HOSPITALIZATIONS/SURGERIES? PLEASE EXPLAIN:

DOES YOUR CHILD PLAY SPORTS? HOURS PER WEEK? AGE CHILD BEGAN?

SPORTS/ACTIVITIES:

WEIGHT OF SCHOOL BACKPACK:

# ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE:

## As a family chiropractic office, we focus on your child’s ability to be healthy. Our goals are: first, to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

***If your child has no symptoms or complaints, and is here for wellness services, please check here ,***

## others need to briefly describe the chief area of complaint, including the effect it has on the child.

WHEN DID THIS BEGIN?

IS THE CHILD EXPERIENCING PAIN? (CIRCLE): SHARP, DULL/ACHY, VARYING, TRAVELS, CONSTANT SINCE THE PROBLEM STARTED, IS IT: (CIRCLE) ABOUT THE SAME, GETTING BETTER, GETTING WORSE

WHAT MAKES IT WORSE: BETTER:

IT INTERFERES WITH: (CIRCLE) SCHOOL, SLEEP, WALKING, HOBBIES/SPORTS, OTHER:

OTHER DOCTORS SEEN FOR THIS PROBLEM:

…………………………………………………………………………………………………………………

# AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: RELATIONSHIP: DATE:



1130 Westport Suite 5 Manhattan, KS 66502

611 Lasley St. Mary’s, KS 66536

Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

|  |  |
| --- | --- |
| **First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred method of communication for patient reminders** (Circle one):Email / Phone / Mail

**DOB:**  \_\_/\_\_/\_\_\_**Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_**

***Smoking Status (Circle one*):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

***Race (Circle one):*** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

***Ethnicity (Circle one):***Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?**

(Please include regularly used over the counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Check this box if you choose to decline receipt of your clinical summary after every visit**

*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_ /\_\_\_\_\_\_ HR\_\_\_\_\_\_\_ |