

Infant New Patient Form



CONFIDENTIAL PATIENT INFORMATION

Welcome to North Sea 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:	Partner'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:

- | | | | |
|-----------------------------------------------|------------------------------------------|------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Low energy | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Irritability | <input type="checkbox"/> Frequent colds / infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficult to wind | <input type="checkbox"/> Worse at night | <input type="checkbox"/> Fevers | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Pulling legs up | <input type="checkbox"/> Seizures / fainting | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Constant crying | <input type="checkbox"/> Cold hands / feet | <input type="checkbox"/> 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:..... / /