INFANT INTAKE FORM (0- 2 YEARS)

Name (first, middle, last)________________________________ Date _______________

Phone Number__________________ E-Mail Address ______________________________

Address________________________ City_______________ State_____ Zip___________

Date of Birth: ____________ Age: ______

Emergency Contact: ______________ Relationship_________ Phone_______________

Name of Insured:____________________Birthdate:__________

How did you hear about our clinic? ____

Have you had chiropractic care before? **Y N** Name of last chiropractor ______________

What are your goals and/or concerns for your child?

1. ____
2. ____
3. ____

Pregnancy History of Mother

Did you experience any of the following during your pregnancy?

- ☐ Breech position during pregnancy
- ☐ Severe stress
- ☐ Preeclampsia
- ☐ Severe Morning Sickness
- ☐ Fertility Drugs or IVF
- ☐ Medications/Supplements taken:____

Any history of miscarriage? **Y N** If yes, how many? _______

Any major health problems or concerns during the pregnancy? **Y N**

If yes, please list:____

The Birth

Was the birth: **Vaginal** **C-Section** **VBAC**

How many weeks old was baby when born?_____

Were you given Pitocin? **Y** **N**

Was the cord wrapped? **Y** **N**

Any adverse events during the labor or birth? ____

Did your baby receive any antibiotics? **Y** **N**

Did your child receive vaccines? **Y** **N** Did your child react to the vaccines? **Y** **N**

Infancy Years

Does/Did your child experience any of the following:

Difficulty latching/sucking? **Y** **N** Painful? **Y** **N**

Are they: **Breast fed** **Formula Fed** **Bottle Fed**

Difficulty/Slow to burp **Y** **N**

Frequently sounds congested? **Y** **N** Worse at **night** or **morning**? Snoring? **Y** **N**

Do they seem gassy? **Y** **N** Does it smell like rotten eggs? **Y** **N**

Excessive Drooling? **Y** **N**

Frequent spit up/ reflux? **Y** **N**

Colicky? **Y** **N** Is there a time of day that is worse? ______________________________

Ear infections? **Y** **N** Tubes? **Y** **N**

Antibiotic use? **Y** **N** If so, approximately how many rounds? _____

Seems distressed **Y** **N**

Evaluated for tongue/lip tie? **Y** **N**

If released, who performed the procedure? ______________________________

Bowel Movements (Circle all that Apply)

Daily **Constipation** **Diarrhea** **Withholding**

Sleep Quality: **Good** **Fair** **Poor** **Startles easily** **Restless**

Concerns: ____

Musculoskeletal Concerns: (Circle all that apply)

Torticollis **Difficulty with tummy time** **Distorted Skull**

C- Shaped Body **Poor Head Control (Floppy baby)**

Childhood Development:

Were milestones learned in correct order (*Rolling, Sit, Crawl, Stand, Walking*) **Y N**

Any difficulty with crawling? **Y N** (Circle all that apply)

Scooted **Bear Crawl** **Army Crawl** **Did not crawl on all fours**

Toe Walker? **Y N**

Sits in a "W"/ frog position (predominantly)? **Y N**

Appears Clumsy? **Y N**

Immune System:

Skin issues or rashes? **Y N** (Circle all that apply)

Eczema **Psoriasis** **Persistent Cradle Cap** **Hives** **Dry skin**

Cracked/Red Anal ring present? **Y N**
Hair frequently smells like a wet dog? **Y N**
Frequent colds, sinus infections, or UTIs? **Y N**
Frequent biter? **Y N**

Environmental Allergies**?** **Y N** ____
Food Allergies or Sensitivities? **Y N** ____

Food

Is your child a picky eater? **Y N** Explain: ____________________________________
Does your child seem to crave **sugar** or **salt**?
Approximate consumption per day: Water _______ Cow's Milk _____ Soda/Other____

CONSENT TO EXAMINE AND TREAT A MINOR

I, the parent or legal representative, of___________________________authorize the performance of a diagnostic examination, x-rays, and treatment of this child of which Leahy Chiropractic P.A. may consider necessary or advisable in the course of treatment.

____ ______________________

Parent's Signature Date

H I P A A

(HEALTH INSURANCE PORTABILITYACCOUNTABILITY ACT)

Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Leahy and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information abouttreatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.
You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longerbe protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (#164.524).

This notice is effective as of________________, 20_. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Child's Name:________________________

Parent's Signature____________________________________Date ________________