INFANT INTAKE FORM

Child's Name: ______________________ Todays Date: ______________

Mother's Name: ______________________ Father's Name: ______________________

Address: ____

City: ______________________ State/Zip: ______________________

Phone: Home (_____)____________ Mother's Work (_____)____________ Cell (_____)____________

Father's Work (_____)____________ Cell (_____)____________ Other ______________

Primary Insurance: ____

Secondary Insurance: ____

Date of Birth ____________ Birth Weight: ____________ Birth Length: ____________

Sex: ( ) Male ( ) Female Number of Siblings: ____________

Family Medical History: (Please check all that apply and describe below)

( ) Allergy, Asthma, Eczema ( ) Cancer ( ) TB ( ) Scoliosis ( ) Ulcer
( ) High Blood Pressure/Stroke ( ) Heart Problems ( ) Liver Disease ( ) Mental illness
( ) Diabetes ( ) Hepatitis ( ) Other ______________________

Child's Current Medications, including frequency and dosage if know. If none check here: ( )

Medication	Start Date	Medication	Start Date
1)		3)	
2)		4)	

List any known allergies to any medications. If none, check here: ( )

1)		3)	
2)		4)	

Please describe the patient's feeding/eating history (include breast or bottle, introduction of solids, allergies): ____

____

____

Please describe patient's immunization history: ______________________

____

Please list at what age your child was able to sit-up, crawl, stand alone, and walk alone: ____________

____

____

Please list any history of surgery and accidents: ______________________

____

Please describe any other traumas that your child has been involved in: ______________________________

____

Present condition/Reason for seeking chiropractic care: ____

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____

Child's Primary Physician Name: ____

Physician Address: ____

____ Physician Phone: ____________________________

CONSENT FOR TREATMENT OF MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. Strawberry G. Weber D.C. and whomever she may designate as assistant to administer treatment as deemed necessary to:

____

(Name of Minor Child)

Date: ____________________________

Signature: ____

Print Name: ____

Relationship to Patient: ______________________________