POMAJZL Chiropractic

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Pediatric (Infant) Patient Intake

Patient Name:_________________________ Parent/Guardian Name:____________________

Cell/Home Phone:______________________ Work Phone:____________________________

Address:____

Email address:__________________________ Sex: ☐Male ☐Female

How did you hear about us?____

Birth Date:___________________ Age:___________ Child SS#:____________________

Birth Weight:_______ Current Weight:________ Birth Length:______ Current Length:________

Birth History

Delivery: Natural Vaginal Scheduled Cesarean Emergency Cesarean

Location: Home Birthing Center Hospital

Interventions(s): Breech Induction Epidural Vacuum Forceps

At how many weeks was your child born?________ Presence at birth: ☐Jaundice ☐Cyanosis

Congenital Anomalies/Birth Defects:____

Infant Feeding (how long?): Breast:___________ Formula:__________

Name of Obstetrician/Midwife/Family MD:____

Date of last visit to MD:_________________ Purpose:___________________________

Immunization History: ☐On schedule ☐Delayed schedule ☐None

Has your child ever been treated on an emergency basis? If yes, please describe.____________

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Present History (Purpose for the visit):____

____

When did the condition first begin?____________________ Onset? ☐Suddenly ☐Gradually

Is this condition: ☐Improving ☐Getting worse ☐Constant ☐Intermittent ☐Unsure

Acknowledgement & Consent:

I ______________________, being the parent or legal guardian of ______________________, have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care from POMAJZL Chiropractic.

Parent/Guardian Signature:______________________________________Date:____________

Doctors Comments

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