



FORESIGHT
CHIROPRACTIC

New Patient Information Infant & Toddlers

❖ Please complete the following information:

Child's Name _____

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell: _____

Best number to reach you: _____

Birth Date: _____

Email address : _____

❖ Birth History:

Labor & Delivery: [] Easy [] Moderate [] Difficult

Type of Delivery: [] Vaginal [] C-Section

[] Forceps [] Other

❖ Regarding Your Child : Yes No

Is your child accident prone? [] []

Has your child had any falls down steps? [] []

Has your child ever been in a vehicle accident? [] []

Has your child been hospitalized or had surgery? [] []

Has your child ever had any broken bones? [] []

Has your child been vaccinated? [] []

Is/was your child breast fed? [] []

Is your child on formula? _____

Has your child been hit or fallen on head? _____

Comments: _____

Does your child experience any of these problems?

[] Headaches [] Learning challenges [] Ear Infections

[] Breathing [] Colic [] Irritability

[] Sleeping [] Underactive [] Sinus/Allergies

[] Asthma [] Eating disorder [] Stomach problems

[] Spitting up [] Frequent Colds [] Hyperactivity

[] Diarrhea [] Constipation [] Rashes

Has your child been diagnosed with any neuro-developmental disorders such as ADD, ADHD, Asperger? [] Yes [] No

If yes, by whom? _____ When? _____

What actions have you taken? _____

Has your child been on antibiotics [] Yes [] No

If yes, why and how many times? _____

Does the child take:

— Omega Fatty Acid [] How much/how often? _____

— Vitamin D? [] How much/how often? _____

— Vitamin /Mineral? [] How much/how often? _____

— Probiotic? [] How much/how often? _____

Describe your child's sleeping habits.

Describe your child's bowel movements.

Additional Health Issues: _____

Currently taking medications: _____

Foresight Chiropractic Wellness Center

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www.ForesightChiropractic.com



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I understand and agree that health insurance is an agreement between the carrier and me. I understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment.

Parent or guardian signature authorizing care

Child's Name: _____

Parent/guardian (pls. print) _____

Signature: _____

Date: _____

Acknowledgement of HIPPA Privacy Act.

My signature acknowledges I have read and understand the HIPPA Act and that I may ask for a copy for my records.

Signature: _____ Date: _____

Relationship to patient: _____