LAKE
HEALTH + CHIROPRACTIC

Infant/Toddler Form

Child's name _____ Date of Birth _____

Address_____ City_____ State _____ Zip _____

Parent's/guardian name(s)_____

Cell Phone _____-_____-_____ Home Phone _____-_____-_____

What is the reason for today's visit? _____

When did the problem start? _____

Is it getting better or worse with time? _____

Are there any factors that make it better or worse? _____

Is there a history of any of the following conditions?

- ☐ Acid reflux
- ☐ ADD
- ☐ ADHD
- ☐ Asperger's
- ☐ Autism
- ☐ Cerebral palsy
- ☐ Colic
- ☐ Congenital anomalies

Please list _____

_____

- ☐ Difficulty eating
- ☐ Difficulty walking
- ☐ Down's syndrome
- ☐ Ear infection (chronic)
- ☐ Bed wetting
- ☐ Epilepsy
- ☐ Febrile convulsions
- ☐ Fever
- ☐ Pain _____

_____

- ☐ Foot flare
- ☐ Headache
- ☐ Inability to thrive
- ☐ Jaundice
- ☐ Seizures
- ☐ Sleeping problems
- ☐ Speech difficulties
- ☐ Torticollis
- ☐ Other _____

_____

How was the baby delivered?

- ☐ C-section
- ☐ Vaginal delivery at home
- ☐ Vaginal delivery with epidural
- ☐ Vaginal delivery without epidural

Were forceps used? (circle one) YES NO UNKNOWN

Was vacuum extraction used? (circle one) YES NO UNKNOWN

How many hours was the labor? _____

How long was the pushing (in minutes)? _____

Was this a single childbirth or multiple?

- ☐ Single
- ☐ Identical twins
- ☐ Identical triplets
- ☐ Fraternal twins
- ☐ Fraternal triplets
- ☐ Other

_____

What was the birth weight? _____

How many inches long? _____

What was the final APGAR score? 1 2 3 4 5 6 7 8 9 10 UNKNOWN

At how many weeks was the child born? _____

Has the child received vaccinations? YES NO UNKNOWN

Were nutritional supplements prescribed or taken during pregnancy? YES NO UNKNOWN

If yes, please explain _____

Were any invasive procedures performed during pregnancy? YES NO UNKNOWN

If yes, please explain _____

Did the mother have any illnesses during pregnancy? YES NO UNKNOWN

If yes, what vaccinations? _____

Where there significant falls or trauma to the mother during pregnancy? YES NO UNKNOWN

If yes, please explain _____

Any evidence of birth trauma?

- ☐ Bruising
- ☐ Cord around neck
- ☐ Fast/slow birth
- ☐ Odd shaped head
- ☐ Respiratory
- ☐ depression
- ☐ Stuck in birth canal
- ☐ Unsure
- None

Was the child breastfed? ☐ Yes, still actively ☐ Yes, until _____ months ☐ No

Was formula introduced? (check one below)

☐ Yes, still actively ☐ Yes, at _____ months ☐ Yes, until _____ months ☐ No

Has cow's milk been introduced? ☐ Yes, at _____ months ☐ No

Have solid foods been introduced? ☐ Yes, at _____ months ☐ No

Does the child have any food intolerances or allergies? YES NO UNKNOWN

If yes, explain _____

Which developmental milestones have been achieved?

1 month

- ☐ Feeds slowly
- Sucks effectively
- ☐ Focuses eyes
- ☐ Watches moving objects
- ☐ Reacts to bright lights
- ☐ Has good muscle tone
- Responds to loud sounds
- ☐
- ☐

1-4 months

- ☐ Can support head well
- ☐ Can grasp objects
- ☐ Can focus on moving objects
- ☐ Smiles
- ☐ Reacts to loud sounds
- ☐ Acknowledges new faces
- ☐ Is not upset by new people/surroundings

4-8 months

8-12 months

- ☐ Has good muscle tone
- ☐ Can hold head steady
- ☐ Can sit on own
- ☐ Responds to noises or smiles
- ☐ Is affectionate
- ☐ Reaches for objects
- ☐ Crawls
- ☐ Doesn't drag one side when
- ☐ crawling
- ☐ Stands without support
- ☐ Finds obvious hidden objects
- ☐ Says words
- ☐ Uses gestures
  Points or shakes head "no"

CONSENT TO TREAT

I certify that I am the patient or the legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information above to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me.

I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Parent or Guardian Signature _____