

**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 1-4 months

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