Krieser Chiropractic
Family Wellness Center

Infant/Child Intake Form

Today's Date___/___/____

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Patient Name _____ S/S_____-_____-_____
First MI Last

Guardian/Parent Name_____ S/S_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____/_____/_____ Height_____ Weight_____ **Sex:** Female Male

Emergency contact _____ Phone: _____

Your Employer_____ Occupation_____

How did you hear about our office? _____

Health History:

Have you (X) or a family member been diagnosed with any of the following conditions?

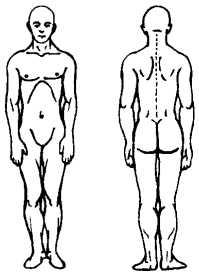
____Heart Disease ____Cancer ____Diabetes ____High Blood Pressure ____Stroke ____Other_____

What are your primary health concerns for your child?

_____
_____
_____

Does your child experience any of the following? (X any that apply)

____ uncontrolled crying
____ difficulty feeding
____ difficulty crawling
____ respiratory problems
____ sleeping problem
____ colic
____ difficulty turning head
____ constipation
____ frequent ear infections
____ digestive problems



Please indicate the area/s of complaint

Other: _____

How was the birthing process (vaginal/c-section) any complications, please explain _____

_____ How long was labor? _____

When did you first notice these symptoms? _____ Is the condition getting worse? No Yes

Have they had this problem before? No Yes When? _____

Have they had any falls, injuries or accidents? Describe _____

Have they ever been to a chiropractor before? No Yes How was your experience? _____

Currently taking the following medications for the following reasons: _____

_____

Surgical History: _____

Pediatrician Name: _____ Phone: _____

Guardian Signature: _____ Date: _____