

Hall Family Chiropractic
Newborn Intake Form (Birth to 2 months)

Please complete fully so we can help your child best.

Child's Legal Name:	Today's Date: ____/____/____
Address:	City/State/ZIP:
Home Phone:	Parent's Cell Phone:
Birth date: ____/____/____	Social Security #:
Mother's Name:	Father's Name:
Siblings Names and Ages:	
Who may we thank for referring your child?	
Does your child have health insurance? _____ Name of company: _____	
Policy # _____ Policy holder _____	

Please select any of the applicable reasons for your pursuing chiropractic care for your child:

I recently had my spine checked and see the value in a family subluxation check-up.

I'm concerned about his/her health and am looking for answers.

He/she has a specific condition that concerns me.

If so, please explain:

I have no idea why we are here. (That's okay; we will take the time to explain what we do).

Do you have family members with similar health concerns? _____ If so, who? _____

Other doctors he/she has seen for this problem: _____

Has your baby been in an auto accident or had a 'near miss'? _____. If so, when was it? _____

Surgeries your child has had: _____

Known Allergies: _____

Has your baby been vaccinated? _____ If so, which vaccines? _____

List any current medications: _____

List any past medications: _____

Does your child go to sleep easily? _____

Does your child have a preferred sleeping position? _____

Does your child have any feeding difficulties? _____

Prenatal History:

Adopted? _____

Complications during pregnancy? _____ If so, please explain: _____

Ultrasounds during pregnancy? _____ If so, how many? _____

Medications/drugs/caffeine during pregnancy? _____ If so, please list type and amount: _____

Cigarette/Alcohol use during pregnancy? _____ If so, please list type and amount: _____

Location of birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention: ___ Mother Induced ___ Mother Medicated (Pitocin, etc.)

 ___ Forceps ___ Vacuum Extracted

 ___ Baby given Medication after delivery; List: _____

Complications during delivery? _____. If so, please explain: _____

Genetic Disorders/Disabilities? _____. If so, please explain: _____

Breast Fed? _____ How long? _____ Formula Fed? _____ How long? _____

Does your baby often spit up after feeding? _____ Does he/she have frequent intestinal gas? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, changing table, down stairs, etc.).

Was this the case with your child? _____. Please explain: _____

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.)? _____. If so, please list: _____

Do you have any other concerns you wish to discuss? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

