Northern Family Chiropractic

13968 Cypress Drive – Suite 1B

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218.822.3855/218.822.3854

Infant Intake

Patient Name:_____ Date:_____

Address:_____ City:_____ State:_____ Referred by:_____

Date of Birth:_____ Age:_____ Sex: M F (please circle)

Mother's name:_____ Father's Name:_____

Address if different from child:_____ City:_____ State:_____

Phone number/Contact number:_____

Siblings:

Name:_____ Age:_____ Sex: M or F

Name:_____ Age:_____ Sex: M or F

Name:_____ Age:_____ Sex: M or F

CHIEF COMPLAINT

Reason for visit today:_____

Date of onset:_____ Onset was: (please circle) Sudden Gradual Assoc. w/ an Event

Duration of problem:_____ minutes / hours / days

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Initiating factors:_____

Aggravating factors:_____

Relieving factors:_____

Effects of problems on body function and daily activities:_____

IMMUNIZATIONS

Has the patient been immunized? YES NO Have you noticed any reactions to the vaccination? YES NO

If yes, what have you noticed?_____

ILLNESSES

Please list any illnesses:_____

GENERAL SYSTEMS REVIEW

Has your child ever been unconscious or had a convulsion?_____

Have you noticed any problems with the eyes, including vision?_____

FAMILY PHYSICAIN/PEDIATRICIAN

Name of Pediatrician:_____ Date of last exam:_____

Please list any significant findings:_____

Is the patient currently being breast fed? YES NO Any problems with breast feeding? YES NO

BIRTH PROCESS

Was the delivery: Vaginal or C-Section

Was there a midwife assisting in the birthing process? YES NO Midwife's name:_____

Did the pregnancy go full term? YES NO If no, what was the duration of the pregnancy?_____

Circle any of the following which were used during delivery: Fetal monitor Forceps Vacuum Extraction Medications

Were there any problems or significant events during the birthing process? YES NO If yes, what problems did you experience?_____

FAMILY MEDICAL HISTORY

Please check if any blood relative to the patient has or had any of the following illnesses and mark accordingly by noting M (mother), F (father), S (sibling), PGM (paternal grandmother), MGM (maternal grandmother), PGF (paternal grandfather), or MGF (maternal grandfather).

_____ Allergy, Asthma, or Eczema

_____ Cancer

_____ Diabetes or low blood sugar

_____ Heart Trouble

_____ High blood pressure

_____ Kidney disease

_____ Liver Disease

_____ Mental Retardation

_____ Mental Illness

_____ Scoliosis

_____ Ulcer

_____ Other:_____

ADDITIONAL INFORMATION

Use this space for further information concerning specific items previously checked:

_____

_____

_____

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Erica L Johnson to administer chiropractic care as deemed necessary to my child.

_____

Name of Child

_____

Date

_____

Guardian Signature

_____

Witness Signature