FORESIGHT
CHIROPRACTIC

New Patient Information
Infant & Toddlers

❖ Please complete the following information:

Child's Name_____

Parent's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Cell:_____

Best number to reach you:_____

Birth Date:_____

Email address :_____

❖ Birth History:

Labor & Delivery: [ ] Easy [ ] Moderate [ ] Difficult

Type of Delivery: [ ] Vaginal [ ] C-Section

[ ] Forceps [ ] Other

❖ Regarding Your Child : Yes No

Is your child accident prone? ..... [ ] [ ]

Has your child had any falls down steps? ..... [ ] [ ]

Has your child ever been in a vehicle accident? [ ] [ ]

Has your child been hospitalized or had surgery? [ ] [ ]

Has your child ever had any broken bones? ..... [ ] [ ]

Has your child been vaccinated? ..... [ ] [ ]

Is/was your child breast fed? ..... [ ] [ ]

Is your child on formula? _____

Has your child been hit or fallen on head? _____

Comments: _____

Does your child experience any of these problems?

[ ] Headaches	**[ ] Learning challenges**	**[ ] Ear Infections**
[ ] Breathing	**[ ] Colic**	**[ ] Irritability**
[ ] Sleeping	**[ ] Underactive**	**[ ] Sinus/Allergies**
[ ] Asthma	**[ ] Eating disorder**	**[ ] Stomach problems**
[ ] Spitting up	**[ ] Frequent Colds**	**[ ] Hyperactivity**
[ ] Diarrhea	**[ ] Constipation**	**[ ] Rashes**

Has your child been diagnosed with any neuro-developmental disorders such as ADD, ADHD, Asperger? [ ] Yes [ ] No
If yes, by whom? _____ When?_____
What actions have you taken? _____
_____
_____

Has your child been on antibiotics [ ] Yes [ ] No
If yes, why and how many times? _____
_____

Does the child take:
Omega Fatty Acid [ ] How much/how often?_____
_ Vitamin D? [ ] How much/how often? _____
_ Vitamin /Mineral?[ ] How much/how often? _____
_ Probiotic? [ ] How much/how often? _____

Describe your child's sleeping habits.
_____
_____

Describe your child's bowel movements.
_____
_____

Additional Health Issues:_____
_____
_____

Currently taking medications:_____
_____
_____

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www.ForesightChiropractic.com

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I understand and agree that health insurance is an agreement between the carrier and me. I understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment.

Parent or guardian signature authorizing care

Child's Name: _____

Parent/guardian (pls. print) _____

Signature: _____

Date: _____

Acknowledgement of HIPPA Privacy Act.

My signature acknowledges I have read and understand the HIPPA Act and that I may ask for a copy for my records.

Signature: _____Date: _____

Relationship to patient: _____

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