



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: \_\_\_\_\_

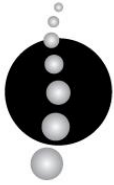
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Foresight Chiropractic Wellness Center

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[www.ForesightChiropractic.com](http://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: \_\_\_\_\_