CONFIDENTIAL PATIENT INFORMATION (INFANT)

Childs Name: First _____MI _____Last _____Age: _____
Address: _____City: _____State: _____Zip: _____
Parent (s)/Guardian(s): _____
Home Phone: _____ Work Phone: _____ DOB: _____
Occupation: _____ Employer: _____
Siblings Name(s) & Age(s): _____
_____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____

Insurance Information
If you are insured and wish for us to assist you in submitting your claims, please provide us with your insurance card so that we may make a copy and verify your coverage in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOUR INFANT TO THE OFFICE

Briefly describe the chief area of complaint, including the effect it has had on your child's life. _____
_____
_____
Since the problem started, is it … About the same Getting better Getting worse
What makes it worse? _____
Yes, it interferes with: Sleep Play Crawling Nursing
Does he/she suffer from any condition other than that which you are now consulting us? Yes / No Please explain._____
_____
When did this problem first appear? _____Has he/she experienced this in the past? Yes / No
Doctors seen for this problem: Chiropractor(s) _____ Medical Doctor(s) _____
Describe any treatment(s) received for this problem so far: _____
_____
Has anyone in your family experienced similar problems? Y / N If so, who? _____

When did your child first respond to sound _____ respond to Visual Stimuli _____
Cross Crawl _____ Sit Up _____ Stand alone _____ Hold head up _____
Prescription medications may cause various side effects, hide the severity of health conditions and or hinder the body's ability to heal. What medications is your infant currently taking? _____
_____
Number of doses of Antibiotics your infant has taken: During the past six months: _____, during his/her lifetime: _____
Number of doses of Other Prescription Medications your child has taken: During past six months: _____, during his/her lifetime: _____ List: _____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) your child has ever had, even if they do not seem related to the current problem.

Colic	Irritability	Sleeping problems	Diarrhea
Constipation	Fever	Allergies	Colds
Ear Infections	Bronchitis	Other: _____	

Describe anything significant about the birth of child: _____
_____

Patient's/Guardian's Signature:_____Date: _____

ALIGN HEALTH & WELLNESS
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