ASCEND
CHIROPRACTIC

Date: _____

Patient # _____

New Patient Intake Form

0-12 Months of Age

_____

Child's First Name | Child's Last Name | Age | Date of Birth | Sex

_____

Parent/Guardian's Name | Relation to Child

Primary Phone Number: _____ **HOME** **CELL**

Please list any other health professionals they're receiving care from and their specialty:

_____

Chief Complaint

Please list the main reason for bringing your child into **Ascend Chiropractic:**

_____

When did this issue begin? _____

How often does this issue occur? ☐**Constantly** ☐**Comes and goes**

How much does it affect daily activities/routines? ☐**Not at all** ☐**Somewhat** ☐**Often** ☐**All the time**

Prenatal History

Is your child adopted? ☐**YES** ☐**NO**

Did you take any medications during your pregnancy? ☐**YES** ☐**NO** If yes, what? _____

Did you smoke during pregnancy? ☐**YES** ☐**NO** Did you consume alcohol during pregnancy? ☐**YES** ☐**NO**

Did you have any complications during pregnancy? ☐ **YES** ☐ **NO** If yes, explain:

_____

Did you have an ultrasound during this pregnancy? ☐ **YES** ☐ **NO** If yes, how often?

_____

Birth History

Birthing place: ☐ Home ☐ Birthing center ☐ Hospital

Type of birth: ☐ Vaginal ☐ C-section

Provider: ☐ Midwife/doula ☐ OB-GYN ☐ Other: _____

Was your labor induced? ☐ **YES** ☐ **NO**

What position did you deliver in: ☐ Squatting ☐ On back ☐ Other: _____

Were any medications used? ☐ **YES** ☐ **NO** If yes, what type? _____

Birth trauma: ☐ Doctor assisted ☐ Twisting and/or pulling ☐ Vacuum extraction ☐ forceps

If there was any newborn trauma, please explain: _____

APGAR Score: At birth ___/10 After 5 minutes ___/10 ☐ Unsure

Did your child have a misshapen skull/head? ☐ **YES** ☐ **NO**

Did your child have purple markings on their face/head? ☐ **YES** ☐ **NO**

History

Do you/did you breastfeed your child? ☐ **YES** ☐ **NO** If yes, for how long? _____

Does your child prefer one breast/side over the other? ☐ **YES** ☐ **NO** If yes: ☐ **Right** ☐ **Left**

Does your child have any allergies? ☐**YES** ☐**NO** If yes, please list: _____

Has your child been immunized according to the recommended schedule? ☐**YES** ☐**NO**

Reason for vaccination: ☐ **Informed decision** ☐ **Recommended** ☐ **Didn't know I had a choice**

If yes, did they have any negative reactions? ☐ **YES** ☐ **NO** If yes, were they reported? ☐ **YES** ☐ **NO**

Has your child ever had any surgeries? ☐ **YES** ☐ **NO** If yes, explain: _____

Has your child ever been on antibiotics? ☐ **YES** ☐ **NO** If yes, how many rounds? _____ Reason: _____

Is your child currently taking any medications? ☐ **YES** ☐ **NO** If yes, what type? _____

Is your child currently taking any vitamins? ☐ **YES** ☐ **NO** If yes, what type? _____

Have any of the following occurred?

☐ Fall from a changing table	☐ Tonsillitis	☐ Frequent ear infections	☐ Reaction to vaccines
☐ Repeated infections/colds	☐ Constipation	☐ Frequent fevers	☐ Fall down stairs
☐ Sleeping problems	☐ Colic	☐ Fall out of crib	☐ Involved in car accident
☐ Inadequate weight gain	☐ Frequent diarrhea	☐ Play in a Johnny Jumper	
☐ Fall off of a playground unit		☐ Other: _____	

If any are checked, please explain: _____

How would you rate your child's diet? ☐Well balanced ☐Average ☐High amounts of sugar/processed foods

How many ounces of water does your child drink per day? _____

Does your child drink milk? ☐ **YES** ☐ **NO** If yes, how much per day? _____

Number of hours your child sleeps: _____ /day (nap) _____/night

Has your child been diagnosed with any other diseases/disorders? ☐ **YES** ☐ **NO**

If yes, please list: _____

Is there anything else we should know about your child? _____

_____

_____

_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Austin Krantz of **Ascend Chiropractic** to administer care as he deems necessary to my child. I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Signed: _____ Date: _____