Funnell Family Chiropractic Baby Entrance Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Baby's name: _____ Today's date: _____

Date of birth: _____ Age: _____ Sex: Male / Female (Please circle)

Address: _____

Postal address if different from above: _____

Phone: Home: _____ Business (Please include contact name):_____

Mobile: _____ Email address: _____

Names of Parents/Guardians: _____

Name of person who referred you (e.g. Midwife, friend's name…):_____

Reason for visit to us today**:** _____

_____

Previous Chiropractor: _____ Date of last visit: _____

Name of Plunket Nurse: _____ Date of last visit: _____

Name of Medical Doctor: _____ Date of last visit: _____

Pre-natal History**:**

Name of Midwife/Obstetrician: _____

Complications during pregnancy? □ No □ Yes List: _____

Ultrasounds during pregnancy? □ No □ Yes Number: _____

Medications during pregnancy/delivery? □ No □ Yes List: _____

Cigarette/Alcohol use during pregnancy? □ No □ Yes

Birth History**:**

Location of birth: □ Hospital □ Home

□ Forceps □ Vacuum extraction (Ventouse) □ Normal Vaginal □ Breech □ Induced

□ Caesarian section: Emergency / Planned

Complications during delivery? □ No □ Yes List: _____

Genetic disorders or disabilities? □ No □ Yes List: _____

Birth weight: _____ APGAR Scores: _____

Feeding History:

Breast fed: □ No □ Yes How long? _____

Formula fed: □ No □ Yes How long? _____ Type: _____

Has your baby fed well off one breast/side in preference to the other? _____

Developmental History:

During the following times your baby's spine is most vulnerable to stress and should routinely be checked by a Chiropractor for early detection and correction of vertebral subluxation (spinal nerve interference). At what age was your child able to?

Hold head up _____ Crawl _____ Sit up _____ Stand alone _____ Walk alone _____

According to the US National Safety Council, approximately 50% of babies fall headfirst from a high place during their first year of life (i.e., from a bed, changing table, down stairs, etc.). Was this the case with your baby? □ No □ Yes

Sometimes the following symptoms may be an indication that your baby has subluxations. Has your baby experienced any of the following?

□ Colic □ Ear infections □ Seizures □ Chronic Colds □ Digestive Problems

□ Constipation □ Reflux □ Allergies □ Other _____

Does your baby have any known health conditions? _____

_____

Number of courses of antibiotics your baby has taken: In the last six months: _____ Total during lifetime: _____

Please list other prescription medications taken: _____

Have you chosen to have your baby vaccinated? □ No □ Yes

Has your baby had any surgery? □ No □ Yes List: _____

_____

No. of hours sleep per night _____ Quality of sleep: □ Good □ Fair □ Poor

Does your baby settle well? □ No □ Yes

Are there any positions your baby does not like? (E.g. lying on back or stomach)_____

Has your child been diagnosed as having Congenital Hip Dislocation (Clicky Hips)? □ No □ Yes

Do you have a preferred appointment time? Yes/ No When? _____

On your visit today you will see the Chiropractor for a consultation; they will check your baby's spine and gently make any chiropractic adjustments if necessary.

Please ensure your mobile phone is switched off.

Authorization for care of minor

I hereby authorize this office and its Chiropractors to administer care to my baby as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Parent/Guardian: _____

Signed: _____ **Date:** _____

We are here to serve you, and encourage you to ask questions.

Your participation is vital and will help determine your baby's results.