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Electronic Health Records Infant Intake Form

In compliance with requirements for the government CMS program

❐Male ❐Female **Social Security #** ___ ___ ___/___ ___/___ ___ ___ ___

Last Name_________________________ **Legal First Name**__________________ **DOB:** ___/___/___

Address:____
(City) (State) (Zip Code)

Home Phone: (____)____-_____ **Cell phone:** (____)____-______ **Email:**________________________

Parents Name: ___________________________ **Medical Doctor name(s)**_______________________

Will an insurance company be <u>contributing</u> to your infant's care? ❐No ❐ Yes *(If no, ask us about our great wellness plans)*

Primary: ________________________________ ***Secondary***: _________________________________

Waiver: I authorize Fixen Chiropractic and the insurance company to process claims with my infant's information. *(signature)*____ *(date)* ___/___/___

Waiver: I authorize the insurance company to release data and to contribute to my infant's care at Fixen Chiropractic. *(signature)*____ *(date)* ___/___/___

Waiver: I have been offered a copy of Fixen Chiropractic's *Notice of Privacy Practices* and the following person(s) have permission to any and all of my infant's records.

____

*(signature)*____ *(date)* ___/___/___

Waiver: I understand that there are minimal risks associated with Chiropractic Care, Acupuncture, and Physiotherapies.
*(signature)*____ *(date)* ___/___/___

Waiver: I, as a parent/legal guardian of _____________________ authorize appropriate chiropractic care.
____*(date)*___/___/_____
(Parent/Guardian Print Name) *(Parent/Guardian Signature)*

How was your infant referred to Fixen Chiropractic? *(Check One)*

❐Patient ______________________ ❐Internet ____________________ ❐Location
❐Physician ____________________ ❐Radio ❐Other _________________
❐Phone book ___________________ ❐Newspaper

Preferred Language: *(Fill in the Blank)* ____________________________

My infants race is: *(Check One)*

❐American Indian/Alaska Native ❐Black ❐White
❐Asian ❐Pacific Islander ❐Other _________________

My infants ethnicity is: *(Check One)*
❐ Hispanic or Latino ❐Not Hispanic or Latino

What is your infant's major symptom/problem? ____
When did symptoms begin? ____
Has your infant experienced this before? ❒No ❒ Yes, when? _______________________________________
Is the condition getting progressively worse? ❒No ❒ Yes
Is this problem: ❒Constant ❒Comes and Goes
What makes the condition better for your infant?____
What makes the condition worse for your infant? ____

Hospital/Birthing Center: ❒Home ❒Medical ❒Midwife Duration of Gestation:____________ weeks

Was the birth assisted? ❒Yes ❒No
If yes, how? ❒Forceps ❒Vacuum Extraction ❒C-Section ❒Induced Labor

Were medications given to the mother at birth? ❒Yes ❒No
If yes, what?_____________________________ Duration of birth:________________

Was the delivery normal? ❒Yes ❒No If no, what complications were there at birth?_________________

Was your infant alert & responsive within 12 hours of delivery? ❒Yes ❒No
If no, explain:____

Postnatal: Number of **wet** diapers per day?_____________ Number of **soiled** diapers per day?___________

Does your infant's sibling(s) have any health problems? ❒Yes ❒No
If yes, describe:____

During the pregnancy, did the mother:
Smoke ❒Yes ❒No
Drink Alcohol? ❒Yes ❒No
Take Drugs? ❒Yes ❒No
Take supplements/vitamins?
❒Yes ❒No
Become ill? ❒Yes ❒No
If yes, how?______________

Was your infant breast fed? ❒Yes ❒No If yes, how long?___________________________
Any difficulties with lactation? ❒Yes ❒No **Any problems bonding?** ❒Yes ❒No
At what age was: Formula introduced?___________ Cow's milk?_________ Solid Foods? ____________

Any pets at home? ❒Yes ❒No
Did/Does your infant go to daycare? ❒Yes ❒No From what age?_____________________
Has your infant had antibiotics? ❒Yes ❒No If yes, how long?___________ What for?_________________
Has mom had antibiotics while pregnant? ❒Yes ❒No If yes, how long and for? _____________________
Is your infant exposed to second hand smoke on a regular basis? ❒Yes ❒No
Does your infant have any behavior problems? ❒ Yes ❒No If yes, what? __________________________
Does your infant have difficulties sleeping? ❒Yes ❒No If yes, specify? ______________________________

Is there any evidence of trauma during birth?

❒Bruises ❒Fast or excessively long birth ❒Cord around neck
❒Odd shaped head ❒Respiratory difficulties ❒Other_________________
❒Stuck in birth canal

Were there any falls/accidents during pregnancy? ❒Yes ❒No

Has your infant had any major falls or trauma since birth? ❒Yes ❒No

Were there any hospitalizations for your infant? ❒Yes ❒No
If yes, please explain:____

Has your infant been seen by a chiropractor in the past? ❒No ❒ Yes **When?** ______________________
Doctor's name?____

Conditions your infant has or have had: *(Check all that apply)*

Migraines (G43) ❒/Headaches❒	IBS(K58) ❒/Constipation❒	ADD/ADHD (F90) ❒
Scoliosis (M41) ❒	Eating Disorder(s)___________❒	Epilepsy (G40.9)❒
Torticollis (M43.6)❒	Colic (R10.83) ❒	Excessive Weight Loss/Gain❒
Ear Ache/Ear Infections❒	Frequent Choking ❒	Jaundice(P59.9<3 mo)❒
Juvenile Rheumatoid Arthritis(M08.00❒	Asthma (J45) ❒	Type 1 Diabetes (E10.9)❒
Psoriasis(L40.9)❒	Eczema (L21.1) ❒	Hepatitis ❒ A(B15.9) ❒ B(B19.10) ❒ C(B19.20)
Bladder Problems ❒	Sinus Infections❒	Night Sweats ❒
Kidney Problems❒	Frequent Colds/Flu/Illness/Fevers ❒	Night Terrors❒
Bed Wetting❒	Anxiety (F41.9)❒	Cancer_________________❒
Acid Reflux (P78.83<3mo/K21.9>3mo)❒	Depression (F41.8)❒	Other__________________❒
Nausea/Vomiting❒	Fatigue ❒	
Celiac Disease (K90.0)❒	Austism (F84.0) ❒/Asperger's (F84.5)❒	

Has your infant had any surgeries/hospitalizations? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Type of Surgery	Date	What was it for?	Any reaction?
	___/___/____		❒Yes ❒No
	___/___/____		❒Yes ❒No

Is your infant currently taking medications, prescription drugs, and pain killers?
(Please include regularly used over the counter medications) ❒No ❒Yes

Prescription Name	Dosage	Frequency	What is it for?

Is your infant currently taking supplements or vitamins? ❒No ❒Yes
(Please include regularly used over the counter vitamins)

Supplement Name	Dosage	Frequency	What is it for?

Does your infant have any allergies? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Allergy Name	Reaction	Onset Date	Additional Comments
		___/___/___	
		___/___/___	
		___/___/___	

Summary of your family history. *(Please check type and list whom)*

Cancer

❒Thyroid(C73)__________ ❒Liver(C22.9)___________ ❒Ovarian(C56.9)__________ ❒Prostate(C61)___________
❒Colon(C18.9)__________ ❒Lung(C34.90)___________ ❒Brain(C71.9)____________ ❒Skin(C43.9)__________
❒Testicular(C62.90)______ ❒Uterus(C55)____________ ❒Pancreatic(C25.9)________ ❒Throat(C15.9)_____________
❒Breast(F-C50.919/M-C50.929)___________ ❒Other__________

Diabetes

❒Type 1(E10.9)____________ ❒Type 2(E11.9)________________

Heart Attack/Disease(I25.2) ❒__________________

Blood Pressure

❒High(I10)________________ ❒Low(I95.0)___________________

Scoliosis(M41.9) ❒____________

Stenosis(M48.00) ❒____________

Disc Disorder

❒Thoracic/Lumbar(M51.9)____________ ❒Cervical(M50.90)_______________

Has your infant had any vaccinations and/or injections? ❒No ❒Yes *If yes, (fill in appropriate areas)*

Vaccination Name	Date	What was it for?	Any reaction?	
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❒ No, I **do not** want a summary receipt after every visit.
❒ Yes, I want a summary receipt even though it may be blank.

Parent/Guardian Signature____ Date____/____/____