GENESIS CHIROPRACTIC CENTER
WHERE THE BRAIN AND BODY RECONNECT

Confidential Infant Intake Form

Child's Name: _____**Child's Birth Date**: ___/____/_____ **Date**: _____

Male/Female (circle one) **GCC #** _____

Mother's Name: _____ Father's Name: _____

Mother's Phone #: _____ Father's Phone #: _____

Reason for consulting our office: _____

Whom may we thank for referring you: _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Labor Time: _____ Difficulty of Labor: _____ Birth: Cesarean / Vaginal (circle one)

Epidural: **Yes or No** Apgar Scores: 1st _____ 2nd _____

Date of last check up: _____

Birth Weight: _____ Current Weight (last physical): _____

Birth Height: _____ Current Height (last physical): _____

Surgery: _____

Allergies: _____

Other Comments:

_____

_____

_____

_____

Physician note area:

I certify that the above information is correct, and I request services as the guardian of the patient.

Guardian Signature: _____ Date: _____