Family First Chiropractic
1193 Daniel Island Drive
Charleston, SC 29492

Family First Chiropractic
9217 University Blvd. C1D
North Charleston, SC 29406

Phone: 843.471.1909 / 843-553-9700
Fax: 843-553-9731

INFANT INTAKE FORM
(Birth to 12 months)

Date ______________________________
Patient Name ______________________________
Parent Name(s) ______________________________
Address ______________________________
City, State, ZIP ______________________________
SSN ____________ DOB ____________ Age_____ Sex ______
Home Phone ____________________ Cell ____________________
Email Address ______________________________

PURPOSE FOR CONTACTING US

Reason for this visit: ______________________________
____

Other doctors seen for this condition? YES NO
If yes, Doctor's names & prior treatment ______________________________
____
Other health problems? ______________________________
Family health history ______________________________
Previous chiropractor ______________________________
Date of last visit __________ Reason ____________________
Name of Pediatrician ______________________________
Date of last visit __________ Reason ____________________
Vaccination history ______________________________

PRENATAL HISTORY

Name of midwife or obstetrician ______________________________
Complications during pregnancy? Yes No ____________________
____
Complications during delivery? Yes No ____________________
____
Ultrasounds during pregnancy? Yes No How many __________
Medications during pregnancy/delivery? Yes No How many __________
____
Location of birth: Hospital Birthing Center Home
Birth intervention: Forceps Vacuum extraction
Caesarean Section: Yes No Emergency Planned
Apgar Score _____ _____
Cigarette/Alcohol during pregnancy? Yes No How much __________
Genetic disorders/disabilities? Yes No ____________________
____
Birth Weight __________ Birth Length __________

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FEEDING HISTORY

Are you breastfeeding? Yes No
Are you formula feeding? Yes No Regular _____ Soy _____

We are here to serve you and encourage you to ask questions, your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Family First Chiropractic to administer care to my son/daughter as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office if they are not covered by insurance.

Name of Insurance Company ____

Policy number ____

Policy Holder's Name ____

Policy Holder's DOB ________/________/_________

Parent / Guardian Name ____

Guardian Signature ____

Relationship to Minor ____

Date ________/________/_________

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: ____________________ **Last Name:** ________________________**DOB:**_________________

Email Address: ____@_________________________________

Preferred method of communication for patient EHR reminders (Circle one): Email / Phone / Mail

Preferred Language: ____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling (circle): (brother/sister)	Offspring (circle): (son/daughter)
Example: Heart Disease				

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient/Guardian Signature: ____ Date: _________________