Infant (Newborn to 1 Year Old)

1. First Name: Last Name: DOB:

2. MRN #:

3. **Home Address**

Address 1 Address 2

City State Zip Code

4. **Contact Information**

Mobile Phone Home Phone

Primary Email Address Social Security Number

5. **Demographic Information**

Sex:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. **Personal Information**

Height - Feet: Height - Inches:

Weight (in pounds):

7. **Do you have Blue Cross Blue Shield?**

○ Yes ○ No

8. **Insurance Payer**

Insurance Payer

9. **Insurance Policy Information (BCBS only):**

Insurance Plan Name ID/Policy Number: Group Number:

Relationship to Patient:
○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: Insured's Date of Birth:

10. **Insurance Card Upload**

11. **Emergency Contact Information**

Emergency Contact Name: | Contact Phone Number: | Relationship to Patient:

12. Referral Information

Referring Physician: | Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

Child's History

13. Have you ever received a formal diagnosis?

○ Yes ○ No

If yes, please specify:

14. Chief complaint in order of importance 1-5

	Complaint
1	
2	
3	
4	
5	

15. Pregnancy and Delivery Complications:

○ Yes ○ No

If yes, please specify:

16. Has formula ever been supplemented?

○ Yes ○ No

17. Any issues early on with the following?

☐ Sucking ☐ Latching ☐ Illnesses

☐ Eczema ☐ Collic ☐ Reflux (excessive spitting up)

☐ Other ☐ None

18. Breastfed?

○ Yes ○ No

19. Age when food was introduced?

20. Does the child consume any of the following:

- ☐ Dairy
- ☐ Gluten
- ☐ Corn
- ☐ High Sugar
- ☐ High Carbohydrates
- ☐ Artificial Dyes and Colorings
- ☐ None

21. Does the child have any adverse reactions to any of the listed above? Are there any known food sensitivities or allergies?

- ☐ Yes
- ☐ No

If yes, please specify:

_____

22. Please check any of the following that apply:

- ☐ Eczema
- ☐ Asthma
- ☐ Allergies
- ☐ Infections
- ☐ Chronic Ear Infections
- ☐ Strep Infection
- ☐ Raised Bumps on Skin
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sinus Infections
- ☐ Other
- ☐ None

If other, please specify:

_____

23. How frequently do they have bowel movements?

_____

24. Any sleeping issues?

- ○ Yes
- ○ No

If yes, please specify:

_____

25. Parent Relationship:

- ☐ Married
- ☐ Divorced
- ☐ Seperated
- ☐ Live Together

26. Occupation

	Job
Father	
Mother	

27. Developmental Milestones

	Age	Not Applicable
Sit Up		
Roll Over		
Crawl		
Walk		
Talk		

28. Does this child make eye contact?

- ○ Yes
- ○ No

29. Do they look in a mirror?

○ Yes ○ No

30. Do they recognize or know body parts?

○ Yes ○ No

31. Do they feel pain?

○ Yes ○ No

32. Have you eliminated any of the following from their diet or your diet?

☐ Gluten ☐ Dairy ☐ Soy

☐ Other

If other, please specify:

_____

Daily Activities

33. What does the child prefer for playtime?

_____

34. How much daily screen time?

_____

35. Do they prefer to be indoors or outdoors?

_____

Familial Health History

36. Does either parent have any chronic health issues?

○ Yes ○ No

If yes, please specify:

_____

37. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												
None												

Supplements

38. Have you ever had any of the following test ran?

- ☐ Blood Test
- ☐ MRI
- ☐ Gentetic
- ☐ Stool Testing
- ☐ EEG
- ☐ Allergy
- ☐ Other

If other, please specify:

_____

39. **Has the child received any other treatment? Were they beneficial? Did you notice any improvement and which was the most effective?**

Parent / Legal Guardian

Signature