Dr's Shaun & Lana Patterson
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New Patient Health Profile (Infant 0-5)

Today's Date (M/D/Y): ________________________________

Last Name: ____ First Name: ____

Parent/Guardian Name(s): (Mom) ______________________ (Dad) ____

Date of Birth (M/D/Y): ________________________________ Age: __________________ Gender: O M O F

Home #: ____ Cell #: ____

Address: ____ City & Postal Code: ___________________________________

Email Address: ____

Who can we thank for sending you to our office? ____

DESCRIBE YOUR PRIMARY CONCERN(S): ____

When did it start? ____ Frequency of Symptoms: ______________________________

Previous treatments for this complaint: ____

BIRTH HISTORY

Birth Weight: _________________

Intervention: O None O Forceps O Vacuum Extraction O Cesarean Section

Complications during delivery? O Yes O No

Was your child breast fed? O Yes O No *If Yes, for how long?* __________________________________

HEALTH HISTORY

Has your child ever suffered from the following (please check all that apply): O Concussions O Ear Infections

O Chronic Colds O Colic O Respiratory Issues O Digestive Issues O Growing Pains

O Other: ____

Rate your child's quality of sleep: O Excellent O Good O Okay O Poor O Terrible

List any food allergies or intolerances: ____

List any medications and/or supplements: ____

Rate the quality of your child's eating/feeding habits: O Excellent O Good O Ok O Poor O Terrible

Does your child have normal bowel movements daily? O Yes O No

Has your child had any major falls, injuries or motor vehicle accidents? O Yes O No *If yes, please list below:*

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Does your child have any genetic disorders or disabilities? O Yes O No *If yes, please list below:*

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