PARTNERS IN HEALING INTAKE FORM

Date:____________________

Name:______________________________ D.O.B._______________

Address:____

Phone Number:_______________________ Email :_______________

Address____

Health issue for seeking treatment;______________________________

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Injuries/Traumas:
(please select the ones you or your child have experienced if any)

___Concussion ___Broken Bone(s) ___Auto Accident

___Childhood accident ___Falls (s) ___Dental work

___Orthodontics ___Surgeries ___NONE

Explanation (if you checked yes to any of the above)

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Childbirth: (Your own or your child)

___Long labor ___Difficult birth(s) ___Easy birth

___C-section ___Vaginal delivery ___Other

___N/A ___I don't know

Early History:

Feeding: (breast/bottle/combination special formula):__________________

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Colic (yes/no):_____________________Reflux:(yes/no):_________________

Flatulance (yes/no):_________________Bowel Issues(yes/no)____________

Any other information that may be relevant:___________________________

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