GINA M. BAKER, LMT
PEDIATRIC HEALTH HISTORY FORM

Date:_____

Child's Name _____ DOB _____

Height _____ Weight _____ Referred by _____

Parent's Name: Mom _____ Dad: _____

Occupation: Mom: _____ Dad: _____

Address _____ City _____

State: _____ Zip: _____ Phone(home): _____

Work/Cell: _____ Email: _____

Emergency Contact Name & Number _____

BIRTH STORY:

_____

_____

_____

_____

_____

_____

_____

CURRENT COMPLAINTS:

_____

_____

_____

_____

_____

_____

_____

MEDICATION/SUPPLEMENT/HOMEOPATHICS:

_____

_____

_____

_____

OTHER TREATMENTS:

_____

_____

BABIES RESENT HISTORY:

YES ___	**NO ___**	**Spitting Up**
YES ___	**NO ___**	**Digestion Issues**
YES ___	**NO ___**	**Tendency to look to one side**
YES ___	**NO ___**	**Sleep Issues**
YES ___	**NO ___**	**Feeding Issues**
YES ___	**NO ___**	**Birth Issues**

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations unless specified under his/her professional scope of practice)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all known conditions and take it upon myself to keep the therapist/practitioner updated on my baby's health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session. PLEASE INITIAL _____.**

_____

Parent or Guardians Signature Date