

Pediatric Potentials

New Patient Information: Newborn/Infant

Today's Date: \_\_\_\_\_ 20\_\_ Physician: \_\_\_\_\_

Baby's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Due Date: \_\_\_\_\_ Weeks gestation: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces Length: \_\_\_\_\_ Inches

Current weight: \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces Length: \_\_\_\_\_ Inches

Breast? Y N Bottle? Y N Pacifier? Y N

Current medications (prescription or supplements): \_\_\_\_\_

Pregnancy comments:

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Vaginal Delivery? \_\_\_\_\_ C-Section? \_\_\_\_\_

Complications at delivery?

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NICU Stay? Dates: \_\_\_\_\_ - \_\_\_\_\_ Please describe:

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Developmental and/or feeding concerns:

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Family goals for baby:

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