INFANT HISTORY

(2 months to 2 years of age)

Date: _____ Name of Mother: _____ Name of Father: _____

Name of Child: _____ Sex: M F Date of Birth: ___/___/____ Age: ___

The reason for today's visit: _____

Yes No

☐ ☐ Has your child ever had this problem before? _____

☐ ☐ Has your child previously been treated for this problem? By whom? _____

☐ ☐ Has your child previously had chiropractic care?

If yes, where? _____ If yes, by whom? _____

NUTRITION:

☐ ☐ Is your child still being breastfed?

If no, for how long was he/she breastfed? _____

If yes, how much cow's milk does the mother consume each day? _____

☐ ☐ Is your child formula fed? Which formula or other milk source? _____

☐ ☐ Is your child eating solid food?

What foods does his/her diet contain? _____

What is your child's favorite food? _____

☐ ☐ Does your child have any feeding difficulties? _____

☐ ☐ Does your child have any digestive disturbances? _____

☐ ☐ Does your child have any food allergies? _____

☐ ☐ Does your child have any persistent or intermittent skin rashes? _____

☐ ☐ Is your child taking any vitamins?

If yes, which ones? _____

TRAUMA: (Describe the trauma and the date that it occurred.)

☐ ☐ Has your child had any recent falls or trauma? _____

☐ ☐ Has your child ever fallen down stairs or fallen from any height? _____

☐ ☐ Has your child ever been in a motor vehicle collision or near miss? _____

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

☐ ☐ Has your child had any other trauma or injuries? _____

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?

_____

GROWTH AND DEVELOPMENT:

☐ ☐ Can your child sit unsupported? At what age did your child start to sit-up? ____ mths

☐ ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

☐ ☐ Is your child walking yet? At what age did your child start to walk? _____mths

☐ ☐ Does your child often trip and fall? _____

☐ ☐ Do you have any other concerns about your child's growth and development? _____

HEALTH HISTORY:

☐ ☐ Has your child had any upper respiratory infections? How often? _____

☐ ☐ Has your child had asthma? _____

☐ ☐ Does your child ever complain of back or neck pain? _____

☐ ☐ Does your child ever complain of pains in the arms or legs? _____

☐ ☐ Does your child ever complain of headaches? _____

☐ ☐ Has your child had any earaches?

At what age did the first earache occur? _____

How frequently does your child have earaches? _____

Do the earaches tend to occur in the same ear? Right ☐ Left ☐ Both ☐

☐ ☐ Has your child had any other illnesses? (Please list each illness and its' approximate date)

_____

☐ ☐ Is your child presently receiving any medications? _____

☐ ☐ Has your child ever been to a hospital/emergency room for evaluation/treatment?

_____

☐ ☐ Has your child been vaccinated recently(date)? _____

☐ ☐ Do you have any other concerns about your child's health? _____

History of Pregnancy

Date: _____
Name of child: _____ Sex: M F Date of Birth: ___/___/___
Mother's name: _____ How many other children do you have? ____
How long did it take you to conceive (with this pregnancy)? _____months/years
What was the term of your pregnancy (at delivery)? _____weeks (40 weeks is considered full term)
What was your estimated due date? _____

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	Describe
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA?	☐	☐	_____
High Blood Pressure?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning Sickness?	☐	☐	_____
Indigestion/Heart burn?	☐	☐	_____
Stress?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen Ankles?	☐	☐	_____
Thyroid Problems?	☐	☐	_____
Heart Problems?	☐	☐	_____
Headaches?	☐	☐	_____
Back Pain?	☐	☐	_____
Abnormal Bleeding?	☐	☐	_____
Were You Hospitalized?	☐	☐	_____
Ultrasounds? If yes, how many?	☐	☐	_____
Any Other Illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	Describe
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication: _____ Reason: _____
Over-the-counter medications?	☐	☐	Medication: _____ Reason: _____

Were you under chiropractic care during your pregnancy? **Y N**
Whom? _____
Did you have massage therapy during your pregnancy? **Y N**
Whom? _____

History of Birth

Date: ___ /___ /___ Name of Child: _____ Date of Birth: ___ /___ /___

LABOR AND DELIVERY:

What was your first sign of labor? _____

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours/minutes

	Yes	No	
Hospital birth	☐	☐	
Name of Hospital:			_____
Physician/Midwife:			_____
Home birth	☐	☐	
Midwife:			_____
Birth Center birth	☐	☐	
Name of Birth Center:			_____
Physician/Midwife:			_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	If yes, why? _____
Emergency C-section	☐	☐	_____
Was Birth Induced	☐	☐	_____
Pitocin:	☐	☐	_____
Breaking bag of waters:	☐	☐	_____
Suppository:	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____

At what point during labor was anesthesia administered? _____

What type of anesthesia was used? _____

Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
Episiotomy/Tearing	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

APGAR Scores: At 1 minute _____/10 At 5 minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth ☐ Cried Strongly ☐ Weak Cry ☐
Baby Did Not Cry for _____minutes

Baby's Color: Pink all over ☐ Blue face ☐ Blue Hands/Feet ☐ Jaundice ☐

Baby's Head: Bruised ☐ Swollen ☐ Red ☐ Misshapen ☐

Baby's Activity: Arms and legs actively moving ☐ Floppy baby ☐

Signs of Trauma: Yes ☐ No ☐

Intensive Care: Was required ☐ Days in Neonatal Intensive Care Unit _____

Medication given at birth (to baby): _____
(to mom): _____

Vaccines administered: _____ Vitamin K ☐ Circumcision ☐

Tests run: _____

Birth weight: _____lbs._____oz. Birth length: _____in.

Baby home on day_____ Mom home on day _____

Breastfeeding: Latched on right away ☐ Difficulty feeding ☐ Didn't Breastfeed ☐

PATIENT INFORMATION

Date: _____

Patient Name: _____ Day Phone: _____

Address: _____ Night Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Date of Birth: ___/___/___ Age: _____ Patient's Social Security Number: ___ - ___ - ____

E-mail Address: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Referred to this office by: Friend/Relative Yellow Pages Insurance Company Other

INSURANCE INFORMATION

Who is responsible for this account? _____

Insurance Company: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ Employer: _____

Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ____

Relationship to patient: _____

Is patient covered by additional insurance? Yes No

Insurance Company: _____

Group Number _____ ID Number _____

Subscriber's Name: _____ Employer: _____

Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ____

Relationship to Patient: _____

Name of Pediatrician: _____ Location of Pediatrician _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also hereby authorize Dr. _____ and whomever she may designate as assistants to administer chiropractic care as deemed necessary for _____ (name of child).

I give Dr. _____ permission to contact my child's pediatrician regarding his/her care? Yes No

_____ _____

Responsible Party Signature Relationship