

To restore and maintain optimum health for you and your family.

Infant Chiropractic Information

(< 14 years old)

Date: _____

Name:	Date of birth:
Home Address and Phone Number:	Names of parents or guardians:
E-mail:	
Family Medical Doctor:	Referred by: <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Add
Name and ages of other children:	Work Number:

Why this form is important:

Our office focuses on your child's ability to be healthy. Our goals are to first address the issues that brought you and your child to this office, and second, offer the opportunity to improve your child's health potential in the future. Life activities include events that cause damage. This damage builds layer upon layer even to levels at which you may **not yet be aware**.

Research is showing that many of the health challenges that occur later in life have their origins during the developing years, some starting at or before birth. We need to know what your child's layers of damage contain, so we ask you to carefully and completely fill out this detailed and important form.

Labour and Delivery

- | | | |
|--|--|--|
| <input type="checkbox"/> Hospital with doctor | <input type="checkbox"/> Hospital with Midwife | <input type="checkbox"/> Home with Midwife |
| <input type="checkbox"/> Breach | <input type="checkbox"/> Caesarian | <input type="checkbox"/> Fetal Monitor Used |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Forceps | <input type="checkbox"/> Length of delivery: _____ |
| <input type="checkbox"/> Complications. Please describe: _____ | | |

Name of Midwife: _____

Prenatal & Infant History

Number of Ultrasounds given during pregnancy: _____

Duration of pregnancy in weeks: _____ APGAR Score at birth: _____

Birth Length: _____ Birth Weight: _____

Please check any problems the patient had at birth:

- | | | |
|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Choking |
|-----------------------------------|-----------------------------------|----------------------------------|

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q Other: _____

Please check if any of the following applied to the patient after birth:

- | | | |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Artificial Feeding | <input type="checkbox"/> Vitamin K |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Other: _____ | | |

Nutrition

Please check if the patient received any of the following:

- | | | |
|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Commercial Formula | <input type="checkbox"/> Cow's Milk |
| <input type="checkbox"/> Goat's Milk | <input type="checkbox"/> Solid Food | <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Fruit Juice | <input type="checkbox"/> Vitamins | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Other: _____ | | |

Developmental History

If your child is younger than 2, please indicate which of the following milestones s/he has reached:

- Hold head up Sits up Crawls Stands alone Walks alone

According to National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie, bed, changing table, down stairs, etc). Was this the case with your child?

Yes No Please describe the circumstances: _____

Has your child ever been involved in any high impact or contact type sports (ie, soccer, football, hockey, gymnastics, baseball, martial arts, etc?) Yes No Please list: _____

Has your child ever been treated on an emergency basis? Yes No. Please describe: _____

Other injuries or falls not described above? Yes No Please list: _____

Prior surgery? Yes No Please list: _____

Onset of first menstrual period: _____

Is your child vaccinated or have you chosen not to vaccinate? If you child has been vaccinated, please list any reactions: _____

Childhood Diseases: Has your child had any of the following illnesses? (please indicate age if applicable)

- | | | |
|---|--|---|
| <input type="checkbox"/> Measles (Rubeola) _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Rubella (German Measles) _____ |
| <input type="checkbox"/> Pertussis (Whooping Cough) _____ | <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Other _____ |

Other Health Concerns:

Patient/ Guardian's Signature: _____ Date: _____