Date: Dr:

INFANT 0 - 4 HEALTH HISTORY

Welcome! *Please complete this form and bring it to your first appointment.*

PERSONAL / PARENTAL CONTACT INFORMATION

Child's Name: Birth date: Age:

Gender: ☐ Female ☐ Male

Parents' names:

Address: City: Postal Code:

Home#: Mobile #:

E-mail:

How did you hear about our office? ☐ Website ☐ Internet ☐ Location ☐ Referral:

Has your child ever been to a chiropractor before? ☐ Yes ☐ No

Name of chiropractor: City:

Date of last visit: Duration and frequency of care:

BIRTH

Duration of gestation(weeks): **Duration of birth**(hours):

Location of birth(hospital, birthing center, home, other):

Assisted? ☐ Yes ☐ No **If yes:** ☐ forceps ☐ vacuum extraction ☐ C-section ☐ induced labour

Medications delivered to mother at birth? ☐ Yes ☐ No If yes, what:

Please describe the birth:

Were there any complications?

Birth weight: **Birth length:**

GROWTH AND DEVELOPMENT

Was your child alert and responsive within 12 hours of birth? ☐ Yes ☐ No Describe:

Any concerns regarding your child's development pattern? ☐ Yes ☐ No Describe:

Any concerns regarding your child's sleep patterns? ☐ Yes ☐ No Describe:

Family history of health problems (cancer, diabetes, heart disease, other):

Mother's side: Father's side: Siblings:

CHEMICAL STRESSORS			
Was your child breast-fed? ☐ Yes ☐ No		How long?	
At what age was the child introduced to …		Formula:	Type:
Cow's milk:		Solids:	Type:
Commercial baby food:		Type:	
Food Intolerance?	☐ Yes ☐ No	Describe:	

During pregnancy, did the mother …		
Take supplements?	☐ Yes ☐ No	Type:
Have an illness?	☐ Yes ☐ No	Type:
Take medications?	☐ Yes ☐ No	Type and reason:
Have an ultrasound?	☐ Yes ☐ No	How many and reason:

Has the child…		
Taken supplements?	☐ Yes ☐ No	Type:
Had an illness?	☐ Yes ☐ No	Type:
Taken antibiotics?	☐ Yes ☐ No	Type:
Had a vaccination?	☐ Yes ☐ No	Type:

PSYCHOSOCIAL STRESSORS			
Any difficulty with lactation?	☐ Yes ☐ No	Any problems with bonding?	☐ Yes ☐ No

Any behavioral challenges? ☐ Yes ☐ No / Describe:

Night terrors, sleepwalking, sleep trouble? ☐ Yes ☐ No / Describe:

Does your child have challenges regulating emotions? ☐ Yes ☐ No / Describe:

Does your child experience anxiety? ☐ Yes ☐ No / Describe:

Does your child have difficulty focusing/concentrating? ☐ Yes ☐ No / Describe:

What is the average # of hours of screen time (TV, tablet, phone or computer) per week?

PHYSICAL STRESSORS

Any evidence of birth trauma? Bruises, odd head shape, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, or other:

Any trauma during pregnancy? (Falls, accidents, etc.) ☐ Yes ☐ No / Describe:

Any falls from couches, beds, or change tables? ☐ Yes ☐ No / Describe:

Any cuts, stitches, fractures, or bruises? ☐ Yes ☐ No / Describe:

Any hospitalizations? ☐ Yes ☐ No / Describe:

Any surgeries? ☐ Yes ☐ No / Describe:

The **nervous system** controls and coordinates all of your body functions. **Chiropractic care** is designed to correct spinal misalignments that inhibit the nervous system, which in turn reduces body function. The following questions will help give us a complete picture of your child's health.

Check any conditions that your child has experienced:

☐ Irritable/Nervousness	☐ Sleeping Difficulty	☐ Low Energy	☐ Acid Reflux	☐ Difficulty turning head
☐ Skin Problems	☐ Poor Digestion	☐ Dizziness	☐ Torticollis	☐ Head shape
☐ Frequent colds/flu	☐ Ear Infections	☐ Toe Walking	☐ Latching /feeding issues	

What would you like to gain from chiropractic care?

Any other concerns we should know about?

How can we make your experience in our office even better?

I give consent to receiving email reminders for my child's appointments:

Signature _____ Date _____