

**INFANT/CHILD HEALTH HISTORY REVIEW – CONFIDENTIAL**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Birthplace: \_\_\_\_\_ First/last name of each Parent: \_\_\_\_\_

Home address of child and each parent: \_\_\_\_\_

\_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # of each parent: \_\_\_\_\_

Email: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Siblings: \_\_\_\_\_

Medical Physician/Pediatrician: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

**PRE-NATAL/NATAL HISTORY:**

Name of Midwife/Obstetrician: \_\_\_\_\_

Mother's health status before and during pregnancy: \_\_\_\_\_

Mother's age at birth: \_\_\_\_\_ Prior pregnancies?: \_\_\_\_\_ Miscarriages?: \_\_\_\_\_

Were any drugs used before or during pregnancy?: \_\_\_\_\_

Ultrasounds during pregnancy?: Yes \_\_\_\_\_ No \_\_\_\_\_ Hospital Birth?: Yes \_\_\_\_\_ No \_\_\_\_\_

Were there any known complications at birth for mother or child? Yes \_\_\_\_\_ No \_\_\_\_\_

Term of the child at birth (e.g., full term or premature)?: \_\_\_\_\_

Duration of labor and delivery: \_\_\_\_\_ Difficult labor/delivery?: \_\_\_\_\_

Spontaneous or induced labor? \_\_\_\_\_ Vaginal or caesarean delivery? \_\_\_\_\_

If caesarean – planned or emergency?: \_\_\_\_\_

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Circle if your child was at any time after the 7<sup>th</sup> month in an in-utero constrained posture:

Breech                      Transverse lie (side lying)                      Face/Brow Presentation

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Please circle any item that applies to this child regarding the time during/after delivery:

- |                       |   |                   |                |
|-----------------------|---|-------------------|----------------|
| a) fetal monitor used | b) forceps, vacuum extraction or other instruments used |                   |                |
| c) medications        | d) breathing problems                                   | e) choking        | f) jaundice    |
| g) surgery            | h) artificial feeding                                   | i) silver nitrate | j) vitamin K   |
| k) circumcision       | l) blue baby (cyanosis)                                 | m) anemia         | n) convulsions |
| o) infections         | p) congenital anomalies                                 |                   |                |

Weight at birth: \_\_\_\_\_ Length at birth: \_\_\_\_\_ Child's APGAR scores? \_\_\_\_\_

**FEEDING HISTORY:**

Breast Fed?: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many months? \_\_\_\_\_ Difficulty Feeding? \_\_\_\_\_

Formula Fed?: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Type? \_\_\_\_\_ Supplements? \_\_\_\_\_

Introduced to solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months.

Food sensitivities: \_\_\_\_\_

**MEDICAL INTERVENTIONS:**

Vaccinations (if any) received to date: \_\_\_\_\_

Any surgeries? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Any medications: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what: \_\_\_\_\_

Medical Treatment in last 12 months?: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what: \_\_\_\_\_

Number of doses of antibiotics taken during the past 6 months \_\_\_\_\_, lifetime doses \_\_\_\_\_

**GROWTH AND DEVELOPMENT:**

age held head up \_\_\_\_\_ (1-2 mo) age sat with support (head steady) \_\_\_\_\_ (3-5 mo)

age rolled from front to back \_\_\_\_\_ (3-5 mo) age sat alone \_\_\_\_\_ (9-11 mo)

stood with support \_\_\_\_\_ (6-8 mo) age walked with support \_\_\_\_\_ (9-11 mo)

age said first word \_\_\_\_\_ (12 mo) age when points to desired objects \_\_\_\_\_ (12 mo)

age walked without support \_\_\_\_\_ (11.5 mo) age at first tooth \_\_\_\_\_

Has your child ever fallen from a high place (bed, change table, stairs, etc.)? Yes \_\_\_ No \_\_\_

Is/was your child involved in any contact sports? Yes \_\_\_ No \_\_\_

Has your child ever been in a car accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever been seen on an emergency basis? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe your child's experience with the following:

What hours will your child sleep on a usual day/night? \_\_\_\_\_

Toileting: \_\_\_\_\_

Speech: \_\_\_\_\_

Habits: \_\_\_\_\_

Discipline: \_\_\_\_\_

Schooling (day care, nursery): \_\_\_\_\_

Personality (independence, relationship with parents, siblings and peers, activities and interests): \_\_\_\_\_

<b>SYSTEM REVIEW OF THE INFANT/CHILD:</b>	<b>Please answer-</b>	<b>YES</b>	<b>NO</b>
1. Has your child experienced weight changes, low energy or recent fever?	_____	_____	_____
2. Skin: Any skin trouble such as rashes, bleeding, dryness, lumps?	_____	_____	_____
3. Head: Any headaches, head injuries, dizziness or balance problems?	_____	_____	_____
4. Eyes: Vision disorders, pain, redness, excessive tearing or glasses/contacts?	_____	_____	_____
5. Ears: Any hearing disorders, infections, ringing in ears or discharge?	_____	_____	_____
6. Nose and sinuses: Frequent colds, nasal stuffiness, sinus trouble or drainage?	_____	_____	_____
7. Mouth and throat: Sore throat, dental trouble, speech trouble or sore tongue?	_____	_____	_____
8. Lymphatics: Enlarged and/or painful lymph nodes?	_____	_____	_____
9. Neck: Lumps/masses, pain, or swollen glands?	_____	_____	_____
10. Breasts: Pain, discharge, masses or asymmetry?	_____	_____	_____
11. Respiratory: Cough, difficulty breathing, frequent colds, allergies or asthma?	_____	_____	_____
12. Cardiovascular: Heart problems, high blood pressure, chest pain or blue baby?	_____	_____	_____
13. Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation, colic, food intolerance, bladder problems, or jaundice?	_____	_____	_____
14. Urinary: Pain, increased frequency of urination, infections or blood in urine?	_____	_____	_____
15. Reproductive: Infections, pain, swelling, testicular masses, painful menses, bed wetting, or sexually transmitted diseases?	_____	_____	_____
16. Musculoskeletal: Joint pain, swelling, back pain, neck pain, bone or muscle pain, sports injuries, arthritis, problems walking or scoliosis?	_____	_____	_____
17. Neuological: Fainting, blackouts, seizures, weakness, numbness, tingling, memory problems, abnormal movements or delayed development?	_____	_____	_____
18. Psychological: Depression, poor memory, nervousness or poor thinking?	_____	_____	_____
19. Endocrine: Thyroid problems, excessive sweating or diabetes?	_____	_____	_____
20. Hematologic: Anemia, bruising, bleeding or transfusions?	_____	_____	_____
21. Has your child ever broken a bone?	_____	_____	_____

**FAMILY HEALTH HISTORY:**

Check if any apply to the child, parents, grandparents or siblings of the child:

- Cancer     Diabetes     Scoliosis     Stroke     Kidney disease  
 Heart trouble     Mental illness     Nerve disorder     High Blood Pressure  
 AIDS     Anemia     Tuberculosis

**DATE OF LAST:**

Spinal examination \_\_\_\_\_      Physical examination \_\_\_\_\_  
 Urine test \_\_\_\_\_      Operation \_\_\_\_\_  
 Hospitalization \_\_\_\_\_      Illness \_\_\_\_\_

**PURPOSE FOR THIS VISIT:**

What is the reason for contacting us? \_\_\_\_\_

How long has the child experienced this? \_\_\_\_\_

Is it getting better or worse over time? \_\_\_\_\_

Have you tried anything for this complaint? \_\_\_\_\_

Have you seen any other health professionals for this? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you content with your child's present level of health? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you interested in wellness for your child? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child eat junk food? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC CARE:**

You understand that the spinal adjustment is used to correct dysfunctions of the spine involving the joints, muscles and nerves that is called a subluxation.

You consent to the performance of a spinal examination in which the doctor uses their hands to feel the muscles and joints of the back and neck (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for the neck and back, and performs any further orthopedic or neurological tests. X-rays or other imaging may be ordered by the chiropractor.

The tests and spinal adjustments are standard and commonly used. They involve very little risk and serious side effects are rare. Stroke is an extremely rare serious adverse effect associated with cervical (neck) spinal manipulation. The best evidence indicates that cervical manipulation for neck pain is much safer than the use of NSAID's (nonsteroidal anti-inflammatory drugs), by as much as a factor of several hundred times. While no adverse effects are anticipated, the risks are the same as those encountered in a routine visit to any doctor of chiropractic. Some patients may have muscle soreness after chiropractic adjustments or after performing standard physical exam tests.

Spinal adjustments have been used routinely in the management of patients with a variety of symptoms and/or disorders, including those without symptoms who want to improve overall health. Chiropractic is considered part of a wellness lifestyle. I have read and understand this informed consent and I consent to chiropractic examination and care.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date