HISTORY OF BIRTH

Hospital/Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ Weeks
Assisted With: □ Forceps, □ Vacuum Extraction □ C-Section, □ Induced Labor Duration of labor: _____
Duration of birth: _____Complications at birth: _____
Medications delivered to mother at birth? _____ Was delivery normal? □ Yes □ No
APGAR at Birth _____ After 5 Minutes _____ Birth Weight _____ Birth Length _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? □ Yes □ No Explain_____
Has child reached all milestones on time? If no, which were delayed? _____
Do sleeping patterns seem normal to you? □ Yes □ No
Family Health Problems: Mother's side_____
Father's side _____ Siblings _____

CHEMICAL/FEEDING HISTORY

Was baby breast-fed? □ No □ Yes How Long? _____ Formula introduced at age _____
Type of formula used: _____ Cow's milk introduces at age _____ Began solid foods at age _____
Food/Juice intolerance □ No □ Yes Type: _____
During pregnancy did mother smoke? □ Yes □ No Drink alcohol? □ Yes □ No
Any illness of the mother during pregnancy? _____
Supplements taken during pregnancy? _____Any drugs taken during pregnancy? _____
Any exposure to ultrasound? □ No □ Yes If so, how many, why?_____
Any invasive procedures (Amniocentesis, CVS)? _____
Any pets at home? □ No □ Yes Any smokers in the home? □ No □ Yes How much? _____
Any vaccinations? □ No □ Yes Which ones, and any reactions?_____
Any antibiotics? □ No □ Yes For:_____Total number of courses of antibiotics to date:_____

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? □ No □ Yes Any problems with bonding? □ Mother □ Father
Any behavioral problems? □ No □ Yes Type:_____ Onset:_____
Any night terrors, sleepwalking, difficult sleeping? □ No □ Yes Specify _____
Age when daycare began? _____ Average number of hours of television per week? _____
Does your child seem normal for their age? □ Yes □ No

TRAUMATIC STRESSORS

Any traumas during pregnancy (falls, accidents)? _____
Any evidence of birth trauma: bruises, odd-shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other? _____
Any falls from couches, beds, change tables? _____
Any traumas with bruising, cuts, stitches, fractures? _____
Any hospitalizations? □ No □ Yes Explain:_____
Any surgeries or organs removed? _____
Sports played and age began:_____ Number of hours per week: _____
Weight of school backpack: _____ Approx hours spent at play per week: _____
Thank you for completing this form. Please write any other questions/concerns you have below.
_____
_____
_____
_____

Child History Form

Date _____

Name_____ Date of Birth _____

Mother's Name _____ Father's Name _____

Mother's Address_____ City _____ State ____ Zip _____

Telephone # _____ Cell _____ Work _____

Father's Address (if different)_____ City _____ State ____ Zip _____

Telephone # _____ Cell _____ Work _____

Referred by _____

Present MD and Address _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____ Witness _____

CHIEF HEALTH CONCERNS:_____

_____

_____

LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT (including medications): _____

_____

_____

Date of Onset _____ Onset was Sudden _____Gradual _____Associated with an event

Duration of problem (episode) _____ □ minutes □hours □days □months □years

Pattern of problem: □ Constant □ Intermittent □ Occasional □ Cyclical

Initiating factors: _____

Aggravating factors: _____

Relieving factors: _____

Effects of problems on body function and daily activities: _____

_____

Prior occurrence or episodes: _____

Prior treatment and results: _____

Present Length/Height _____ Weight _____

OTHER HEALTH CONCERNS:_____

_____

_____

_____