Integrative Chiropractic Pediatrics

Infant & Child Health History Form

Child's Name: _____

Sex: ____M ___F Birthdate: _____

Mom's Name: _____ Dad's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mom's Cell Phone: _____

Dad's Cell Phone:_____ Best # to Call: _____

Email address: _____

IN CASE OF EMERGENCY, CONTACT (Other than parents):

Name: _____ Relationship: _____

Phone: _____

Person(s) responsible for payment:

Name: _____ Relationship: _____

Phone: _____

Mainly for Moms:

1. Tell us about your pregnancy:

Did you carry to full term? _____

Describe any complications and when they occurred: _____

_____

_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy?

For what? _____ What type? _____

Any exposures to ultrasound?_____ How many?_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Obstetrician? _____ Doula?: _____

Delivered in: ___ Hospital ___ Birthing Center ___ Home ___ Other

Did you have a C-Section? ____Yes _____No If yes: _____Planned _____ Emergency

Did you have a Vaginal Birth? _____Yes _____No Were you induced? _____

Were forceps used? _____ Vacuum Extraction? _____

Did you have an Epidural? _____ Any other meds taken? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____

Baby latch ok? _____ Preference for one breast? _____ If yes: ___R ___L

Any issues/concerns with nursing? _____

Baby use a bottle? _____ If yes: ___Breast milk ___Formula

What formula?_____

Now for Child:

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____
_____
_____

6. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other _____

Please explain any of the above: _____
_____
_____
_____

7. Tell us about any vaccinations your child has had: _____
_____
_____

Any reactions to any of these? _____
_____

Were you told that you had a choice in vaccinating your child? ___**YES** ___**NO**
Would you like information on the other side of this issue? ___**YES** ___**NO**

8. Which of the problems you have checked off is the worst? _____

_____

9. **Is this problem: __Constant __Intermittent __Occasional __Cyclic**

10. **How long has it persisted?** _____

11. **When it is at its worst, how does it make your child feel?** _____

12. **What impact is it having on you/your family?**_____

13. **What have you done about it that has NOT worked?** _____

_____

14. **What makes it worse?** _____

15. **What effect does this problem have on your child's body functions**?

_____

_____

On his/her participation in daily activities? _____

16. **Describe any hospital stays:** _____

_____

17. **Approximately how many times have antibiotics been prescribed and for what conditions?**

_____

_____

18. **List any medications your child is currently taking:** _____

_____

19. **To summarize, what is your purpose for this appointment?** _____

_____

20. **Is there anything else you feel we should know?**_____

_____

I certify that all information provided has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to the health of my child.

Signature of parent or guardian: _____**Date:**_____