

INFANT/CHILD HEALTH HISTORY REVIEW – CONFIDENTIAL

Name: _____ Date: _____ Sex: _____ Birthdate: _____

Birthplace: _____ First/last name of each Parent: _____

Home address of child and each parent: _____

Town/City: _____ Province: _____ Post Code: _____

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/age: _____ / _____

Father’s health status before conception/age : _____ / _____

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?: _____

Gas or Pain Medications or Anesthetics (spinal epidural) during birth? _____

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

Breech Transverse lie (side lying) Face/Brow Presentation

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): _____

SYSTEM REVIEW OF THE INFANT/CHILD: Please answer- YES NO

- 1. Has you 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:

Is this visit a checkup? If no, 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 spine or other body parts (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for spinal or other body parts, 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 adjustment. The best evidence indicates that cervical adjustment 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