Infant Patient Information

Childs Full Name: _____ Date: _____

Name Child Uses (nickname): _____ Birthday: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Best Time to Call: _____

Mothers Name: _____ Fathers Name: _____

Email: _____

Number of Siblings: _____ Age of Siblings: _____ Referred by: _____

Name and Number of Person to Contact if we Cannot Reach You: _____

Do you live here full time or seasonal? _____

Any impending vacation or travel plans? Yes No

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may be **physical, chemical** or **emotional** in nature.

Additional Information

_____

_____

_____

_____ _____

Patient Signature (Parent) Doctor Signature

Health History

Today Date: _____

Patients Name: _____ **Sex: M F Date of Birth:** _____ **Age:** _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.
Please circle either yes or no and explain if needed.

How many hours does your baby sleep between feeds? During day:_____ During night: _____

Does your baby go to sleep easily? **Yes No** _____

Does your baby have a preferred sleeping position? **Yes No** _____

Does your baby cry if you change this sleeping position? **Yes No** _____

Does your baby have any feeding difficulties? **Yes No** _____

Is your baby being breast fed? **Yes No** If no, for how long was the baby breast fed _____weeks/mnths

Does your baby have a one sided breast-feeding preference? **Yes No** If yes, Left or Right breast: _____

Is your baby formula fed? **Yes No** If yes, which formula is used/milk source? _____

Does your baby frequently spit-up after feedings? **Yes No** _____

Does your baby cry a lot? **Yes No** If yes, for how many hours each day? _____

Does your baby pass a lot of intestinal gas? **Yes No** _____

Does your baby have a preferred head position? **Yes No** _____

Does your baby frequently arch his/her head and neck backwards? **Yes No** _____

Does your baby cry or become irritable during a diaper change? **Yes No** _____

Has your baby ever had a fever? **Yes No** _____

Has your baby had any falls? **Yes No** _____

Has your baby been in a car accident or near-miss? **Yes No** _____

Has your baby had any other trauma? **Yes No** If yes, explain. _____

Has your baby been vaccinated? **Yes No** _____

Do you have any other concerns you wish to discuss? _____

Birth History

LABOR AND DELIVERY

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (pushing phase) of the labor? _____ hours

Hospital birth? **Yes No** _____

Home Birth? **Yes No** _____

Midwife assisted? **Yes No** _____

Vaginal Delivery? **Yes No** _____

Planned C-Section? **Yes No** _____

Emergency C-Section? **Yes No** _____

Was Birth Induced? (Pitocin) **Yes No** _____

Forceps Delivery? **Yes No** _____

Vacuum Extraction? **Yes No** _____

Anesthesia Administered? **Yes No** _____

Fetal Distress? **Yes No** _____

Meconium Staining? **Yes No** _____

Head Presentation? **Yes No** _____

Face Presentation? **Yes No** _____

Breech Presentation? **Yes No** _____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 Minutes _____/10 At 5 Minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth: _____

Cried Strong _____ Weak Cry _____ Did Not Cry for ____ minutes

Baby's Color: Pink all over _____ Blue Face _____ Blue Hands/Feet _____

Intensive Care: Was required _____ Days in Neonatal Intensive Care Unit _____

Medication given at birth? _____ Vaccines administered:_____

Birth weight: _____ lbs/kgs Birth length: _____ ins/cms Day you took baby home: _____