INFANT HISTORY
Birth to 2 years

Today's Date _____________

Childs Name____ Sex M F DOB_________________ Age__________

Mother & Father's Name ____ Child's SS# _____________

Address ____ City _________________________ zip ____________
Phone # ______________ Work # ________________ Cell # ____________________ email ______________________

How were you referred to the office? ____

Would you like to receive our free monthly health newsletter? Yes No Already Receive

Reason for Today's Visit____

Please give as much detail as you feel necessary to help the doctor understand your answers to the following questions.

GROWTH AND DEVELOPMENT

Yes No Can your child sit unsupported? At what age did your child start to sit-up? ___ mths
Yes No Is your child crawling yet? At what age did your child start crawling? ________ mths
Yes No Is your child walking yet? At what age did your child start to walk? __________ mths
Yes No Does your child often trip and fall? ______________________________________
Yes No Do you have any other concerns about your child's growth and development? ______

HEALTH HISTORY

Yes No Has your child had colic? ____
Yes No Has your child had any upper respiratory infections? How often? ________________
Yes No Has your child had asthma? ____
Yes No Does your child ever complain of back or neck pain? ___________________________
Yes No Does your child ever complain of pains in the arms or legs? _____________________
Yes No Does your child ever complain of headaches? __________________________________
Yes No Has your child had any earaches? At what age did the first earache occur ________
Yes No How frequently does your child have earaches? ________________________________
Yes No Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? _____________
Yes No Has your child had any other illnesses?
Please list each illness and its approximate date ________________________________
____
Yes No Is your child presently receiving any medications? _____________________________
Yes No Has your child ever been to a hospital or emergency room for evaluation or treatment? ___________________________
Yes No Has your child recently been vaccinated? ______________________________________
Yes No Do you have any other concerns about your child's health? ______________________
Yes No Has child's mother / father ever been under chiropractic care?

BIRTH HISTORY

Did you have any problems during pregnancy / labor with this child? ______________________
Were any extraction aids used (vacuum, forceps)? _____________________________________
C-section or vaginal delivery (circle) If C-section, was it planned? Yes No
APGAR Scores 1 min _________ 5 min __________
Any problems immediately following delivery with mother or child? _______________________

Name of Pediatrician:____
Date of Last Visit:______/______/______ Reason:_____________________________________

Are you satisfied with the Care your Child has Received There? _______ No _______ Yes

Number of Doses of Antibiotics Your Child has Taken:
During the Past Six Months:______ , Total During His / Her Lifetime:_______

Number of Doses of Other Prescription Medications Your Child has Taken:
During the Past Six Months:______ , Total During His / Her Lifetime:_______
List:___________________________

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company:______________________________ Policy #:________________
Signed:_________________________ Witnessed:____________________ Date:____/____/____