CHILD HISTORY FORM

What brings you to our office: ____

HISTORY OF BIRTH

Please select one or more of the following: Hospital Birthing Center Home		Delivery by: Midwife Ob/Gyn	Duration of Gestation:
Please select if any of the following applies: forceps, vacuum extraction, c-section, induced labor?			
Duration of Birth?		Complications at birth? Explain	
Birth Weight	Birth Length		
APGAR at Birth		After 5 minutes	

GROWTH AND DEVELOPMENT				
Was the infant alert and responsive within twelve hours of delivery?			Explain:	
Please note N (Normal) or D (Delayed) for the following:				
Hold up head	Vocalize	Sit Alone	Crawl	Walk
Teethe	Sleeping Patterns			
Any health problems (cancer, diabetes, heart disease, etc) on the mother's side of the family?				
On the father's?				
With siblings?				

Problems that chiropractors concern themselves with can be related to many types of stressors; the following is also very important to us.

CHEMICAL STRESSORS:

During Pregnancy did the mother:					
Smoke	Yes	No	Have any illness?	Yes	No
Live with Smokers?	Yes	No	Any pets in the home?	Yes	No
Any smokers in the home?	Yes	No	Drink alcohol?	Yes	No
Have any invasive procedures? (amniocentesis, CVS)					
Any exposure to ultrasound?	What was the medical reason?				
Take any nutritional supplements? Please list:					
Take any medications? Please list:					
About the BABY:					
Breast Fed?			How long?		
Formula introduced at age:			Type of formula used:		
Introduction to cow's milk at age:			Any colic, constipation, or gerd?		
Age and type of solid baby food introduction:					
Any food or juice intolerance?			Describe:		
Total number of courses of antibiotics to date:					
List all medications child has taken/is currently taking:					
Which vaccines has the child been given and please list any reactions:					

Psychosocial Stressors:

Any difficulties with lactation?	Yes	No	Explain:
Any problems with bonding?	Yes	No	Explain:
Any behavioral problems?	Yes	No	Explain:
Any night terrors or difficulty sleeping or bed wetting?	Yes	No	Explain:
Does your child seem normal for their age?	Yes	No	Explain:
Age of child when began daycare:	Average number of hours of television/week:		

Traumatic Stressors:

Describe 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 the neck, other?	
Any falls from couches, beds, change tables?	
Any traumas with bruising, cuts, stitches, fractures?	
Any hospitalizations, explain:	Any surgeries or organs removed?
Sports played and age began:	Number of hours/week played:
Weight of school backpack:	Approx. hours spent at play per week: