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:____/____/____