HEALTH QUESTIONNAIRE – INFANT (0 - 1yrs) **File # _____**

This is a comprehensive questionnaire that is designed for infants. The information you provide is for your infant's benefit and protection. It is for the private use of this office (unless you sign a release for legal purposes) to aid your chiropractor in gaining a better understanding of your infant's condition.

Patient Information:

Name in Full: _____ Today's Date: ____/____/____

Birth Date: _____/_____/_____ Age: _____ Sex: _____

Birth Weight: _____ Current Weight: _____

Birth Length: _____ Current Length: _____

Address:_____Suburb:_____ Postcode:_____

Mother's Name:_____ Mobile #: _____ Email: _____

Father's Name: _____ Mobile #: _____ Email: _____

Names and Ages of siblings *(if applicable):* _____

_____

How did you hear about the clinic? *(Friend / Internet / Facebook **please state**)* _____

_____

Has your child seen a chiropractor before? Yes / No

If yes, who? _____

Medical Doctor's Name: _____ Practice address: _____

Date of last visit to Medical Doctor: _____

Date of last visit to Pediatrician: _____

Please circle the purpose(s) for your child's visit:

Crisis management	Early detection	Prevention	Wellness
Maximizing normal growth & development		Improve immune function	
Other: ***(explain reason of visit)***			

Birth History

What was the child's gestational age at birth? _____weeks

Was your child's birth *(please circle)*: at home, in a birthing centre, hospital, other: _____

Birthing assisted by: obstetrician, G.P., midwife, other: _____

Labour was *(please circle)*: spontaneous, induced

Labour was *(please circle):* average easy prolonged extremely rapid

How long were you in labour? _____ How long did you push for? _____

Was your child born *(please circle)* : cephalic (head first), breech (feet first)

Describe the birth of your child by circling the relevant items:

Term	Premature	Overdue
Vaginal	Caesarean	Breech
Anterior	Posterior	Suction/Vacuum
Induced	Forceps	

Did you encounter any problems during labour / delivery? Yes / No

If yes, please describe? _____

Any other relevant information: _____

What were your child's APGAR scores? @birth:___/10 @5mins:___/10

Was the birth traumatic for your child? _____ Delivery complications? _____

Was your child's head misshapen at birth? _____

Did your newborn have any difficulty starting to breathe? Yes / No

Did your newborn have jaundice? Yes / No

General and Present Health History & Concerns:

Infant Feeding:

Was/is your child breast fed? Yes No If so, for how long? _____

Was/is your child formula fed? Yes No If so, for how long? _____

Is your child eating solids? Yes No When did you start? _____

Supplements? Yes No Type? _____

Are there any problems in the feeding schedule? _____

Does/did your child suffer from colic? Yes No If so… Mild Mod Severe

Does/did your child suffer from reflux? Yes No If so… Mild Mod Severe

If yes, when is/was the crying most intense? _____

Sleep

Number of hours of sleep per night? _____ Time put down for the night? _____

Quality of sleep: good fair poor restless fussy

Does your child sleep *(please circle)* : front / back / side

Digest

Is the urine straw coloured? Yes / No

If no, please describe? _____

Are bowel movements regular? Yes / No

Are bowel movements a yellowish colour and toothpaste consistency? Yes / No

If no, please describe? _____

Does your baby feel stiff on being picked up? Yes / No

Is your child frequently ill? Yes / No

Does your child have allergies? Yes / No

If yes, specify: _____

Is your child having allergy shots? Yes / No

Has your child been vaccinated? Yes / No

Has your child had any reaction to vaccinations? Yes / No

If yes, please describe: _____

How many times has your child taken antibiotics? _____

Growth & Development History:

Was your child alert and responsive within 12 hours of their birth? Yes / No / Unsure

If no, please explain:_____

At roughly what age did your child:

Respond to sound _____ Follow an object _____ Hold up head _____

Vocalize _____ Sit alone _____ Teethe _____ Crawl _____ Walk _____

Physical Stressors:

Since problems that chiropractors look for an detect can be related to many types of stressors, the following information is also very important to me.

Any traumas to the mother during pregnancy? (ie. falls, accidents etc) yes / no

If yes, please explain:_____

Any evidence of birth trauma to the infant:

bruising odd shaped head stuck in birth canal

fast or excessively long birth respiratory depression cord around neck

Any significant falls from couches, beds, change tables etc? yes / no

If yes, please explain:_____

Any significant traumas resulting in bruises, cuts, stitches or fractures? yes / no

If yes, please explain:_____

Has your child been hospitalized or required any surgery, if so when and what for?

_____

Chemical Stressors:

Is your child on or has taken any medications?_____

Is your baby exposed to tobacco smoke on a daily basis? Yes / No

During the mother's pregnancy:

Did the mother smoke? Never smoked no longer smokes quite during pregnancy

Continued smoking during pregnancy: How much? _____

Did the mother drink alcohol? yes / no If yes, how much?_____

Any illnesses during the pregnancy? yes / no If yes, please describe:_____

Any supplements taken during pregnancy? yes / no If yes, please describe:_____

Any drugs taken during pregnancy? yes / no _____

Any pets at home? yes / no type:_____

Any smokers in the home? yes / no

Is the diet organic? yes / no

Do you use 'green products' in your home for cleaning? yes / no

Psychosocial Stressors:

Baby spends most waking hours with: Mother Father Grandparent Sitter
Daycare Other: _____

Any problems with bonding? yes / no _____

Any behavioural problems? yes / no _____

Any inattention? yes / no _____

Any hyperactivity or restlessness? yes / no _____

Any challenges with developmental and delay? Yes / No _____

Any prolonged temper tantrums or separation anxiety? Yes / No _____

Is your child in daycare? Yes / No Age of child when began daycare? _____

Any problems reported at daycare? _____

Do you feel that your child's social and emotional development is normal for their age? yes / no

Are you worried / nervous about your infant receiving chiropractic care? Yes / No

---

Thank you for taking the time in completing this form. If there are any other questions or concerns which you have, please discuss with the chiropractor.

Acknowledgement of Office Policy & Consent:

By signing below you acknowledge consent for a history & physical examination of your child by any of the chiropractic practitioners at Chelsea Chiropractic & Wellness. At any point verbal withdrawal of consent is permitted. A further consent form will be provided for information about any treatment required.

Signature (parent/guardian):_____

Print Name: _____

Date: _____