OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

INFANT (0-24months) Chiropractic Health Form

## PERSONAL INFORMATION

Name of Child: _____ Gender: _____

Name of Parent(s): _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____

Email: _____

☐ Yes ☐ No I consent to receiving email communication from Oaktree

(Emails we will send you include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: __ Height: _____

MD name: _____

Referred by: _____

## CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? ☐ Yes ☐ No

Name of Chiropractor: _____ City: _____

Date of last visit: [M]_____ [Y]_____ Duration & Frequency of Care: _____

## EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____

## CONSENT TO EXAMINATION

I understand that the purpose of today's visit is to determine if my child is a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed. The force used to analyze an infant's spine for subluxation is similar to checking a tomato for ripeness.

_____ _____

Signature Date

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# PRENATAL & BIRTH HISTORY

The time babies spend in the womb is far from idle. The brain is changing more rapidly during this time than at any other time in development. It is an active time for the fetus to grow and explore, and of course connect to its mother. New evidence from in-utero fetal brain scans shows, for the first time, that this connection directly affects brain development: A mother's physical and mental stress during pregnancy changes neural connectivity in the brain and the nervous system of her unborn child.

## PREGNANCY

Complications during pregnancy: ☐ Yes ☐ No Comment:_____

Ultrasounds during pregnancy: ☐ Yes ☐ No How many?:_____

Medications during pregnancy: ☐ Yes ☐ No If yes, what?:_____

_____

Vaccines during pregnancy: ☐ Yes ☐ No If yes, what?:_____

What health concerns (if any) did you experience during your pregnancy?

| | | |
|---|---|---|
| ❑ High Blood Pressure | ❑ Back Pain | ❑ Indigestion |
| ❑ Diabetes | ❑ Abnormal Bleeding | ❑ Swollen Ankles |
| ❑ Anemia | ❑ Other illness/hospitalization | ❑ Thyroid problems |
| ❑ Morning Sickness | ❑ Any other trauma:_____ | |

Was this pregnancy a result of IVF? ☐ Yes ☐ No

Did you experience any miscarriages prior to this pregnancy? ☐ Yes How many?:_____ ☐ No Cigarette/alcohol use during pregnancy: ☐ Yes ☐ No Comment:_____

## BIRTH

Location of birth: ☐ Home ☐ Birthing Centre ☐ Hospital ☐ Other:_____

Type of birth: ☐ Vaginal ☐ C-section

Medications during labour: ☐ None ☐ Induction (i.e. Pitocin, oxytocin) ☐ Epidural ☐ Other:_____

_____

Birth procedure/interventions: ☐ Forceps ☐ Vacuum extraction ☐ Induced

☐ Other:_____

Complications during delivery: ☐ Fast birth ☐ Excessively long birth ☐ Bruises ☐ Odd-shaped head ☐ Stuck in birth canal ☐ Cord around neck ☐ Breech ☐ Respiratory depression ☐ Meconium ☐ Resuscitation ☐ Other:_____

_____

Genetic disorders or disabilities: ☐ Yes ☐ No Comment:_____

Birth weight:_____ APGAR score (if known):_____

Did anything else happen after the birth? ☐ Jaundice ☐ NICU ☐ Medications

Details:_____

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**INFANT HISTORY**

Was your baby breastfed? ☐ Yes ☐ No If yes, for how long?:_____

If breastfeeding, are there any challenges? ☐ No ☐ Yes (check below)

☐ Prefers one side ☐ Gags or chokes frequently ☐ Have tongue/lip ties ☐ Other:_____

_____

If applicable, at what age was your baby introduced to:

☐ Formula:_____ Type(s):_____

☐ Solid foods:_____ Type(s):_____

How many hours between feedings? (If age appropriate):_____

Are you dealing with any of the following issues?

❑ Fussiness/gas ❑ Backward arching of head and neck ❑ Latching Difficulty

❑ Bowel/bladder issues ❑ Reflux ❑ Other:_____

❑ Tilted Head/Neck ❑ Colic

Are you concerned with baby's head/skull development or shape? ☐ No ☐ Yes:_____

How many hours is baby sleeping? (between feedings or during the night if applicable): _____

How many poops does baby have a day?: _____

How many hours per day is baby spending in an 'upright posture'? (i.e. in a car seat, bouncy seat, swing): _____

How much tummy time is baby getting per day? ☐ On parents:_____ ☐ Alone:_____

If you use a baby carrier, what kind? (we ask because some affect hip development):

_____

**CHEMICAL STRESSORS**

Any food intolerances? ☐ Yes ☐ No If yes, list:_____

Has the baby had any vaccinations? ☐ Yes ☐ No ☐ Modified schedule

Has the baby ever had antibiotics? ☐ Yes ☐ No If yes, list:_____

Total number of antibiotic rounds to date: _____

Does the baby take any medication(s)? Which and for what conditions(s)?: _____

_____

**TRAUMATIC STRESSORS**

Falls your baby has experienced (i.e. from a bed, change table, down stairs, off couch, etc.):

_____

_____

Has the baby ever been hospitalized post birth? ☐ Yes ☐ No Comment:_____

_____

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Has the baby ever had surgery? ☐ Yes ☐ No Comment:_____

_____

Has the baby ever been involved in a car accident? ☐ Yes ☐ No Comment:_____

**HEALTH CONCERNS**

**What is the purpose of today's visit?** ☐ Wellness Check-up ☐ Specific Concern (fill out below)

1. What is the present primary health concern for your baby? _____

_____

How long has baby had this condition? _____

What other health care professionals have treated this condition? What else have you tried?

_____

Is the problem: ☐ getting better ☐ getting worse ☐ staying the same

Please rate the problem on how you think this is affecting baby:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please rate the problem on how you think this is affecting your family:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

2. If applicable, what is the present secondary health concern for your baby? _____

_____

How long has baby had this condition? _____

What other health care professionals have treated this condition? What else have you tried?

_____

Is the problem: ☐ getting better ☐ getting worse ☐ staying the same

Please rate the problem on how you think this is affecting baby:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please rate the problem on how you think this is affecting your family:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please share any additional health problems, concerns, or information: _____

_____

_____

_____

_____