



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 #: _____ Office #: _____

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 Were x-rays taken? Yes No

Name of Chiropractor: _____ City: _____

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

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 that similar to checking a tomato for ripeness.

Signature

Date



PRENATAL & BIRTH HISTORY

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

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: _____

Did anything else happen after the birth? Jaundice NICU Medications

Details: _____



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
- Other: _____
- Bowel/bladder issues
- Colic/reflux

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? 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: _____



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: _____

