Infant Health History Form

4 Market Place, Hollis, NH 03049
p: 603.465.2235 f: 603.465.2236

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: M/F

Phone: (H)_____ (C) _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Parent's Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

List Ages of Other Children in Family: _____

Who may we thank for referring you to our office? _____

How would you like appointment reminders sent: [ ] email [ ] text: cell provider _____

Has your child had any Chiropractic care? ☐ Yes ☐ No

Name of Pediatrician: _____

Date of last visit: _____ Reason: _____

Health Profile

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you to the office:

If your child has no symptoms or complaints, and is here for ***wellness services***, please check ☐

Otherwise briefly describe the chief area of complaint, including the effect it has on the child:

_____

_____

Since the problem started, is it: ☐ about the same ☐ getting better ☐ getting worse?

It interferes with: ☐ school ☐ sleep ☐ walking ☐ sitting ☐ hobbies ☐ other: _____

Daily we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges that have influenced your child's health potential.

During your pregnancy, did you experience any of the following? If yes, please describe.

Falls	☐ Yes ☐ No	_____
Motor Vehicle Accidents	☐ Yes ☐ No	_____
High Blood Pressure	☐ Yes ☐ No	_____
Anemia	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	_____
Indigestion	☐ Yes ☐ No	_____
Morning Sickness	☐ Yes ☐ No	_____
Swollen Ankles	☐ Yes ☐ No	_____
Seizures	☐ Yes ☐ No	_____
Thyroid Problems	☐ Yes ☐ No	_____
Heart Problems	☐ Yes ☐ No	_____
Bleeding Issues	☐ Yes ☐ No	_____
Back Pain	☐ Yes ☐ No	_____
Any Other Issues	☐ Yes ☐ No	_____

Any Hospitalizations ☐ Yes ☐ No _____

Had Flu Shot ☐ Yes ☐ No _____

Had DTAP Vaccine ☐ Yes ☐ No _____

How Many Ultrasounds _____

During your pregnancy, did you use any of the following? If yes, please describe.

Fertility Treatments ☐ Yes ☐ No _____

Tobacco ☐ Yes ☐ No _____

Alcohol ☐ Yes ☐ No _____

Prescription Drugs ☐ Yes ☐ No _____

OTC Meds ☐ Yes ☐ No _____

Birth History:

Where was the baby born? ☐ home ☐ hospital ☐ birthing center ☐ other: _____

Location & Name of Birth provider_____

How long was the labor? _____ How long was the pushing phase?_____

Was oxytocin/pitocin used? ☐ Yes ☐ No Was an epidural administered? ☐ Yes ☐ No

Was the delivery: ☐ vaginal ☐ c-section Any Fetal Distress? ☐ Yes ☐ No

Were there any devices used? ☐ forceps ☐ vacuum

Baby presentation ☐ Head ☐ Face ☐ Breech Was intensive care required? ☐ Yes ☐ No

APGAR score at birth:_____ Birth weight: _____

Baby home on Day _____ Medication at birth: _____

Vaccines administered at birth:_____

Feeding History:

Breast fed: ☐ Yes ☐ No How long: _____

Formula fed: ☐ Yes ☐ No How long: _____ Type: _____

Introduced to solids at _____ months. Cow's milk at _____ months

What foods are they currently eating? _____

Does your child have any:

Feeding difficulties ☐ Yes ☐ No _____

Digestive disturbances ☐ Yes ☐ No _____

Food Allergies ☐ Yes ☐ No _____

Persistent or intermittent skin rashes ☐ Yes ☐ No _____

Is your child receiving any vitamin supplements? ☐ Yes ☐ No _____

Developmental History:

At was age was your child able to:

Sit unsupported_____

Cross crawl_____

Walk unsupported _____

Does your child often trip and fall? ☐ Yes ☐ No _____

Do you have any other concerns about your child's growth and development?

_____

_____

Trauma:

Has your child ever:

Had any falls or trauma? ☐ Yes ☐ No _____

Fallen down stairs or fallen from any height? ☐ Yes ☐ No _____

Been in a motor vehicle collision? ☐ Yes ☐ No _____

Had a bone fracture or joint dislocation? ☐ Yes ☐ No _____

Had any other trauma or injuries? ☐ Yes ☐ No _____

Had any emotional trauma? ☐ Yes ☐ No _____

Bang his/her head repeatedly against a wall, bed or other object? ☐ Yes ☐ No _____

Health History

Has your child had any:

Colic? ☐ Yes ☐ No _____

Upper respiratory infections? How Often? ☐ Yes ☐ No _____

Asthma? ☐ Yes ☐ No _____

Back or neck pain? ☐ Yes ☐ No _____

Pains in the arms or legs? ☐ Yes ☐ No _____

Headaches? ☐ Yes ☐ No _____

Earaches? ☐ Yes ☐ No _____

At what age did 1st occur? How many? _____

Do the earaches tend to occur in same ear? Which? _____

Other illnesses? ☐ Yes ☐ No _____

Please list each illness and approx. date_____

Medications? ☐ Yes ☐ No _____

Visits to the hospital or ER? ☐ Yes ☐ No _____

Vaccinations based on recommended schedule? ☐ Yes ☐ No _____

Any complications from vaccines? ☐ Yes ☐ No _____

Do you have any other concerns about your child's health?

_____

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to examine and provide chiropractic care for my child. I hereby authorize this clinic and its Doctor(s) to administer care as they so seem necessary to my son/daughter/ward (upon approval of parent or guardian). I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Parent's signature: _____ Date: _____