AFFINITY CHIROPRACTIC
DR. JANE BIGBY
830 Klamath Ave. ◇ Klamath Falls, OR 97601 ◇ 541-887-8555

Confidential Patient Information for Infant/Toddler

_____/_____/_____
DATE

_____ M ____ F____
NAME

_____/ _____/_____ _____ _____
BIRTHDATE AGE PARENTS NAME

_____ _____ _____
HOME ADDRESS CITY ZIP

_____
MAILING ADDRESS (if not same)

_____ _____ _____
HOME PHONE PARENT CELL PHONE PARENT EMAIL

Method of Payment (circle): Cash/Card Ins Medicare Auto Ins Other

How did you learn of our office: yellow pages TV radio Internet Other:_____ referred by: _____

Emergency Information
Who should we contact in case of an emergency? _____

_____ _____ _____
Home Phone Work Phone Cell Phone

Health care providers
Family doctor: _____ Clinic Name: _____

Other health professional (Nurse practitioner, Massage therapist, PT, OT, Naturopath, Homeopath, etc)
Name: _____ Type of provider: _____

Name: _____ Type of provider: _____

Has the child seen a chiropractor before? Y____ N____ If yes, results:_____

FAMILY HEALTH HISTORY
Indicate who in the family has the history M = mother, F = father, S = sibling, GP = grandparent

- □ Anemia
- □ Arthritis
- □ Asthma
- □ Cancer/tumor
- □ Diabetes
- □ Epilepsy/seizures
- □ Glaucoma
- □ Heart disease
- □ High blood pressure
- □ High cholesterol
- □ Kidney disease
- □ Liver disease/Hepatitis
- □ Lung disease
- □ Osteoporosis
- □ Phlebitis
- □ Psychological problem type:_____
- □ Stroke
- □ Thyroid disease
- □ Tuberculosis
- □ Ulcers
- □ Immune disorder or disease
- □ Other:_____

Wellness profile
The human body is designed to be healthy. The primary system which coordinates health is the nervous system which is protected by the spine. Many of the common health challenges that adults experience have their origins in the developmental years of childhood. Traumas, including birth, may lead to dysfunctional movement of the spine which can decrease health. Please answer the following questions to help us determine the signals that may indicate decreased health in your child.

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Patient's Name:_____ DOB: _____ Date:_____

What signals has your child's body been communicating:

□ Asthma	□ Frequent diarrhea	□ Fail to thrive / slow weight gain
□ Respiratory tract infections	□ Constipation	□ Slow or absent reflexes
□ Sinus problems	□ Flatulence	□ Asymmetrical crawling or walking
□ Ear infections	□ Headaches	□ Weight challenges
□ Tonsillitis	□ Neck pain	□ Bed wetting
□ Strep throat	□ Torticollis / head tilt	□ Sleep problems
□ Frequent colds / croup	□ Trouble feeding on one side	□ Night terrors
□ Recurrent fevers	□ Back pain	□ Tip toe walking
□ Eczema	□ Growing pains	□ Regression of milestones
□ Rashes	□ Scoliosis	□ Seizures
□ Allergies	□ Red, swollen, painful joint	□ Tremors / shaking
□ Food sensitivities	□ Colic	□ ADD / ADHD
□ Digestive problems	□ Frequent crying spells	□ Autism

Do you have a specific concern that brought you to our office: No □ Yes □ If yes, please answer the following questions:
Does your child appear to be in pain or discomfort? No □ Yes □ For how long? _____

Is it getting better, worse, or staying the same? _____ Was the onset sudden or gradual? _____

What makes it better?_____ What makes it worse?_____

Have you seen other health care professionals for this? No □ Yes □ If yes, who? _____

Types of treatment used: _____

Has your child taken any medication for this complaint……. No □ Yes □ _____

Has your child experienced this before…… No □ Yes □ _____

Did they receive any treatment at that time……. No □ Yes □ _____

Has your child had x-rays or other tests for this complaint… No □ Yes □ _____

Prenatal History
Adoption □ Prental history unknown □ Birth history unknown □
Complications during pregnancy: No □ Yes □ Please explain: _____
Ultrasounds during pregnancy: No □ Yes □ If yes, How many? _____
Medications during pregnancy: No □ Yes □ If so, please list (including OTC): _____
_____
Exposure to alcohol, cigarettes, second hand smoke during pregnancy: No □ Yes □

Birth experience
Location of birth: Home □ Hospital □ Birthing center □ Other:_____
Delivery by: Midwife □ GP □ OB □ Other:_____
Medications during labor and delivery (including IV antibiotics): No □ Yes □ _____
Was Pitocin used to start or speed up delivery: No □ Yes □
Was your child at any time during pregnancy in an intra-uterine constrained position: No □ Yes □ Unsure □
If yes, please describe: Breech □ Transverse □ Face / brow presentation □
Was your deliver vaginal or C-section? _____ If C-section, was it planned or emergency? _____
Were any interventions used during the delivery: Forceps □ Vacuum extraction □ Other □ _____
Were there any complications during delivery? No □ Yes □ If yes, please explain _____
_____
How long was the labor from first regular contraction to the birth? _____ Hours
How long was the pushing phase of labor? _____ Hours
Was the baby born with any purple markings on the head or face: No □ Yes □
Any concerns with misshapen head at birth: No □ Yes □

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Patient's Name:_____ DOB: _____ Date:_____

Post natal history
How many weeks gestation was the baby at birth? _____
Birth weight: ____ lbs____oz Birth length: _____in
If known, APGAR score: at birth ___ / 10 at 5 mins ___/ 10
Was the baby every admitted to neonatal intensive care: No □ Yes □ If yes, for how long and why:
_____
Was any medication given to the baby at birth: No □ Yes □ If yes, what medication and why:
_____

Child health history (answer all that apply)
How many hours does your baby sleep between feedings? _____ day _____ night
Does your child have a preferred sleeping position: No □ Yes □ _____
Does your child have any feeding difficulties: No □ Yes □ _____
How is your child fed: Breastfed only □ Breastfed and formula □ Formula only □ Solid food □
If not breastfed, was your child breastfed for any amount of time? No □ Yes □ how long? _____
Does your child have one sided breast preference: No □ Yes □ If yes, right or left? _____
Does your child frequently spit up after feeding: No □ Yes □
Does your child cry often: No □ Yes □ If yes, approximate number of hours per day and time: _____
Does your child pass a lot of intestinal gas: No □ Yes □
Does your child arch his/her body or neck backwards: No □ Yes □
Has your child shown any food sensitivities either in mother's or own diet: No □ Yes □
If yes, what food and response: _____
Is your child exposed to cow's milk/dairy: No □ Yes, formula □ Yes, directly □ Yes, I drink it and breastfeed □

Developmental history
Has your child ever fallen from a high place or down stairs....…...… No □ Yes □ _____
Has your child ever been in a motor vehicle accident or near miss…. No □ Yes □ _____
Has your child ever been seen on an emergency basis……...……. No □ Yes □ _____
Has your child ever broken any bones……. No □ Yes □ _____
Has your child ever been hospitalized……..… No □ Yes □ _____
Has your child had any surgeries…….…… No □ Yes □ _____

Chemical stressors
Have you chosen to vaccinate your child: No □ Yes, on a modified schedule □ Yes, on schedule □
Any of the following reactions to vaccinations? Fever □ Welt at injection site □ Rash □ Diarrhea □ Fatigue □
Seizures □ Developmental regression □ Other: _____
Has your child received the flu shot: No □ Yes □
Has your child received antibiotics: No □ Yes □ If yes, how many doses in the past 6 months? _____
How many glasses of water a day does your child drink? _____
How many glasses of milk, juice, and/or soda does your child drink per day? _____
Does your child eat gluten (wheat products): No □ Yes □ Yes, trying to eliminate □
Does your child eat dairy: No □ Yes □ Yes, trying to eliminate □
Does your child eat refined sugars (white sugar), white breads, or pasta**:** No □ Yes □ Yes, trying to eliminate □
Does your child eat boxed frozen foods: No □ Yes □ Yes, trying to eliminate □
Does your child eat artificial sweeteners: No □ Yes □ Yes, trying to eliminate □
Does your child eat organic foods: No □ Yes □
Does your child have any dietary restrictions: No □ Yes □ If yes, explain: _____
Is your child exposed to second hand smoke: No □ Yes □
Does your child take a probiotic daily: No □ Yes □
Does your child take vitamin D3 daily: No □ Yes □ If yes, daily IU:_____
Does your child take Omega 3 supplements daily: No □ Yes □ If yes, amount and type: _____
Other supplements or homeopathics? _____