Welcome to our clinic!
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Baby & Young Child Consultation History

Name & Nickname: _____ Gender: M or F Date: _____
Address: _____ City: _____Postal Code: _____
Date of birth: _____ Mother's phone number: Home: _____ Bus: _____
Father's phone number: Home: _____ Bus: _____
Height: _____ Weight: _____ Referred by: _____
Present Medical Doctor: _____ Address: _____
Date of last Medical Doctor visit: _____ Reason: _____
Previous Chiropractor's name: _____ Address: _____
Date of last Chiropractor's visit: _____ Reason: _____

Authorization For Care Of A Minor

I hereby authorize _____ and whomever they may designate to administer care as they deem necessary to my son/daughter.
Signed: _____ Witness: _____
Date this _____ day of _____, 20 _____

Chief Complaint

Reason for contacting us _____
List all therapies undergone for this complaint (including medication) _____
_____
Date of onset ___/___/___ Onset was: Sudden Gradual
Duration of pain/problem per episode: ___Minutes ___Hours ___Days ___Months ___Years
Pattern of pain/problem: ___Constant ___Intermittent ___Occasional
Initiating factors _____
_____
Exacerbating factors_____
_____
Diminishing factors _____
_____
Effects of problem(s) on body function and daily activities _____
_____

Pregnancy

At how many weeks of gestation was your child born? _____wks
List any significant complications during pregnancy
_____
_____
_____
Was delivery normal? Yes No If no, list any complications of delivery_____
_____
Duration of labor (hrs)_____ Presentation of baby (i.e. breech)_____
Forceps used for delivery? Yes No
List any medication taken during pregnancy _____
_____
List any medication taken during delivery
_____
_____
Weight at birth: _____ Length at birth: _____

Development History

Please list age in <u>months</u> when child first:
Had head control _____ Rolled over _____ Sat unsupported _____ Stood supported _____
Stood unsupported _____ Crawled _____ Walked unaided _____ Toilet trained: Started _____
Completed _____ Sleep habits _____ hrs/day _____hrs/night Sleep interrupted _____
(# of times)

Nutritional History

Breastfed _____months Formula began age _____for____months
Type of formula used _____ Cow's milk began age _____
Other milk _____
Began solid food at age_____months
Were commercially prepared baby foods used? Yes No If yes, what
type_____
Food/juice intolerance? Yes No. If yes, what type_____

Social Behavior

Seems normal for age Yes No
If "No" explain _____
_____

Childhood Diseases

Y N Chicken Pox (age_____)
Y N Mumps (age _____)
Y N Measles (age _____)
Y N Rubella/German measles (age _____)
Y N Rubella (age _____)
Y N Whooping Cough (age _____)
Y N Other _____(age _____)
Y N Immunization (list type and age) _____
_____

Daily Activities

As a baby/toddler (birth to 4 years), did any of the following occur?

[ ] Fall from changing table
[ ] Tumble down stairs
[ ] Fall out of crib
[ ] Involved in a car accident
[ ] Fall from playground equipment
[ ] Play in a "Jolly Jumper"
[ ] Frequent ear infections
[ ] Frequent crying spells
[ ] Frequent fevers
[ ] Frequent bouts of diarrhea
[ ] Constipation
[ ] Sleeping problems
[ ] Frequent colds
[ ] Colic

As a young child, (5 to 12 years), did any of the following occur?

[ ] Fall from a tree
[ ] Fall off of a bicycle
[ ] Fall from playground equipment
[ ] Sports accident
[ ] Involved in a car accident
[ ] Stomach pains
[ ] Bed wetting
[ ] Hyperactivity
[ ] Learning disabilities
[ ] Asthma
[ ] Allergies or Hayfever
[ ] Other: _____

Medical History

Has your child experienced any of the following:

[ ] Headaches
[ ] Dizziness
[ ] Ringing in the ears
[ ] Neck pain
[ ] Asthma
[ ] Allergies/Hayfever
[ ] Hyperactivity
[ ] Numbness in arms/hand
[ ] Arm or wrist pain
[ ] Sleeping difficulties
[ ] Shoulder pain
[ ] Tingling in arms/hands
[ ] Stomach problems
[ ] Fatigue
[ ] Foot or ankle pain
[ ] Knee pain
[ ] Tingling in legs/feet
[ ] Numbness in legs/feet
[ ] Low back pain
[ ] "Growing pains"
[ ] Other _____

Which of the problems that you have checked off is the worst? _____
_____

How long has this problem persisted? _____
Was the child ever hospitalized? _____
Is the child on any medication at present? _____
List any significant family history (e.g. cancer, diabetes, heart disease, kidney disease, etc.)
_____
_____
Is there anything else that you feel we should know?
_____
_____
_____

Check out our website at www.codiacchiropractic.com

Thank you!