Care Chiropractic
Health & Rehab

INFANT
0-2 YEARS

Patient Information

Child's Legal Name: _____ Preferred Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Mother's Name: _____ Work Phone # : _____ Cell #:_____

Father's Name: _____ Work Phone # : _____ Cell #:_____

Birth Date: D/ ___ M/ ___ Y/ ___ Age: ___   Sex: ❑ M ❑ F   Current Weight: _____   Current Height: _____

AHC #: _____   Do you have health care custodial rights? ❑ Yes ❑ No

Primary Complaint/Reason for visit: _____

Health History

Labor and Delivery

1. Describe any pregnancy complications? _____

2. How many weeks' gestation was the baby born at? _____

3. Was the birth: ❑ Spontaneous   ❑ Induced

4. Was Mothers' test for Strep B: ❑ Positive ❑ Negative   ❑ Unknown

5. Type of Birth: ❑ Forceps ❑ C-Section ❑ Breech ❑ Vacuum ❑ Normal vaginal ❑ Home ❑ Hospital

6. Were there difficulties with the labor and delivery? ❑ Yes ❑ No Explain_____

7. How long was labour? _____   Pushing Phase?_____

8. Was the cord around the baby's neck?   ❑Yes   ❑No

9. What special procedures were needed, if any?_____

10. Baby's Apgar: 1 min. _____ 5 min. _____

11. Baby's: Weight at birth: _____ Length: _____

Newborn Period

1. Was there a required stay in the NICU?   ❑ Yes   ❑ No

2. Is the baby being: ❑ Breastfed   ❑ Bottlefed   ❑ Formula:_____

3. Describe the frequency, length and amount of feeding:_____

_____

4. Describe the frequency of bowel movements:_____

5. List any medications or supplements for the baby:_____

6. List any medications or supplements for Mom:_____

Childhood

Developmental History: At what age did the child:

- ❑ Respond to sound
- ❑ Follow an object with his or her eyes
- ❑ Hold head up
- ❑ Sit alone

- ❑ Crawl-describe_____
- ❑ Stand
- ❑ Walk alone
- ❑ Talk

Has the child ever had or suffered from:

❑ Chickenpox	❑ Tuberculosis	❑ Colds/flu	❑ Ruptures/hernia
❑ Mumps	❑ Colic	❑ Poor Appetite	❑ Leg problems
❑ Measles	❑ Ear Infections/Aches	❑ Constipation	❑ Orthopedic problems
❑ Rubella	❑ Hyperactivity	❑ Stomach aches	❑ Behavioral problems
❑ Rubeola	❑ Convulsions	❑ Poor Appetite	❑ Neck problems
❑ Whopping Cough	❑ Asthma	❑ Blood disorders	❑ Sleeping problems
❑ Rheumatic	❑ Neuritis	❑ Diarrhea	❑ Other
❑ Diabetes	❑ Anemia	❑ Digestive disorders	

_____   _____   _____

Parent's Printed Name   Parent's Signature   Date