

INFANT HISTORY

2 months to 2 years

Child's Name _____ Today's Date _____

Has your child had previous chiropractic care? Yes No When? _____

How many medical doctor office visits did your child have last year? _____ Your family? _____

The following questions are designed to help the doctor provide a detailed examination of your child.

A Few More Health Questions:

Yes No Has your child had any upper respiratory infections? How often? _____

Yes No Has your child had any earaches? At what age did the first earache occur _____
How frequently does your child have earaches? _____

Yes No Does your child's earache usually tend to occur the same ear? Is it right, left or both _____

Yes No Has your child had any other illnesses? _____
Please list each illness and its approximate date _____

Yes No Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes No Do you have any other concerns about your child's health? _____

Nutrition

Yes No Is your child still being breastfed?

If still breast-feeding, how much cow's milk does the mother consume each day? _____

What is your child's favorite food? _____

Yes No Does your child have any feeding difficulties? _____

Yes No Does your child have any digestive disturbances? _____

Yes No Does your child have any food allergies? _____

Yes No Does your child have any persistent or intermitted skin rashes? _____

Yes No Is your child receiving any vitamin supplements? _____

Trauma

Yes No Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred. _____

Yes No Has your child ever fallen from any height? _____

Yes No Has your child ever had a bone fracture of joint dislocation? _____

Child's Name _____ Today's Date _____

Yes No Has your child ever been in a motor vehicle collision or near-miss?

When? Please Describe _____

Yes No Has your child had any other trauma or injuries? _____

Yes No Does your child ever bang his/her head repeatedly against the wall, bed, or any other object?

If yes, what object and when did this behavior start? _____

Growth and Development

Yes No Can your child sit unsupported? At what age did your child start to sit-up? _____mths

Yes No Is your child crawling yet? At what age did your child start crawling? _____mths

Yes No Is your child walking yet? At what age did your child start walking? _____mths

Yes No Does your child often trip and fall? _____

Yes No Do you have any other concerns about your child's growth and development? _____

Lifestyle Information

Does your child get 30 minutes of continuous physical activity each day? Yes No

What type of activity? _____

How much water does your child drink each day? _____

The statements made on this form are accurate to the best of my recollection and I grant permission for this office to examine my child and evaluate their health.

Parent/Guardian Signature

Date