BABY/CHILD HISTORY FORM

Thank you for taking the time to fill out this form. Your responses are important to help us assist your child in achieving the possible health and well-being outcomes.

Date: ________

Child's name: _________________________________ M/F DOB: _______________ Age: _____

Parent/Guardian's Name: ________________________________ Relationship: ___________________

Parent/Guardian's Name: _________________________________ Relationship: __________________

Address: ____

Phone: ___________________________________ Phone: ____________________________________

Email: ____

Who may we thank for referring you? ____

Has your child seen a Chiropractor before? Yes/No Who: __________________ Last visit: ______

What is your main reason for bringing your child to our office? _______________________________

____

Pregnancy

Where there any issues during pregnancy? ____

Birth

Place of birth: ___________________________ Delivered at how many weeks? ________________

How long was the labour? _________________

APGAR score: 1min ____/ 10 5min ____/ 10 Birth weight: _____________ Length: _____________

Was your child's bead misshapen at birth? Yes/No Bruised? Yes/No

Were there any complications? ____

Induction	Epidural	Caesarean
Forceps	Vacuum	Breech
Posterior	Medication used during birth	

Birth to 6 months

Breast fed: Yes/ No For how long? ___________ Preference: Left/Right Difficulties: Yes/No

Formula fed: Yes/No From what age? ___________ For how long? ________________

Was/is your baby 'colicky'? Yes/No

Did/does your baby have reflux? Yes/No Silent reflux? Yes/No

How did/does your baby sleep? ____

Did/does your baby have a daily bowel movement? Yes/No Easily? Yes/No

Was/is your baby unsettled/irritable? Yes/No

Milestones

At what age did your baby/child?

Roll:	Sit:	Start solids:
Crawl:	Walk:	

Eating Habits Excellent Good Fair Poor Terrible

Fussy Eater	Eats fruits and vegetables	Eats junk food
Drinks soft drink	Water per day? ____________	

Does your child have any food allergies/intolerances? Yes/No What? ______________________

Physical Activity Excellent Good Fair Poor Terrible

Does your child play sport or other physical activity? Yes/No What? _______________________

General Health Information

Has your child been to hospital for any reason? ____

Has your child had any significant falls/accidents? ____

____

Has your child broken any bones? ____

Has your child every had antibiotics? Yes/No Has your child had probiotics? Yes/No

Has your child had any other medication? Yes/No What? _____________________________

Does your child take any vitamin or mineral supplements? _________________________________

Has your child been vaccinated? Yes/No

Has your child had any illnesses? ____

Does your child wear orthotics? Yes/No

Does/has your child experienced any of the following? (Please circle)

Constipation/Diarrhoea	Social problems	Hyperactivity	Attention difficulties
Behavioural problems	Diagnosed ADD/ADHD	Diagnosed autism/Asperger's	Learning difficulties
Concentration problems	Anxiety	Seems uncoordinated	Recurrent colds/flus
Ear aches	Ear infections	Asthma	Allergies
Poor appetite	Scoliosis	Growing pains	Joint problems
Lower back pain	Mid-back pain	Neck pain	Headaches
Night terrors	Sleep problems	Bedwetting	Sinus
Clicky hip	Convulsions/Seizures	Recurrent chest infections	Recurrent tonsillitis
Low energy	Epilepsy	Exposure to smokers	Low muscle tone

Is there anything else that may be relevant to your child's health history? ______________________

____

The statements and answers on this form are accurate to the best of my knowledge and I agree to allow this office to examine my child for further evaluation.

Parent/Guardian's Signature: ____ Date: ___________