INFANT HISTORY

(2 months to 2 years of age)

Date: ____________ Name of Mother: __________________ Name of Father:_________________

Name of Child: ____________________________ Sex: M F Date of Birth: ___/___/____ Age: ___

The reason for today's visit: ____

Yes No

☐ ☐ Has your child ever had this problem before? ____

☐ ☐ Has your child previously been treated for this problem? By whom?_______________________

☐ ☐ Has your child previously had chiropractic care?

If yes, where? _____________________ If yes, by whom? ______________________

NUTRITION:

☐ ☐ Is your child still being breastfed?

If no, for how long was he/she breastfed?____________________________________

If yes, how much cow's milk does the mother consume each day?___________________

☐ ☐ Is your child formula fed? Which formula or other milk source? ___________________________

☐ ☐ Is your child eating solid food?

What foods does his/her diet contain? ____

What is your child's favorite food? ____

☐ ☐ Does your child have any feeding difficulties? ____

☐ ☐ Does your child have any digestive disturbances? ____

☐ ☐ Does your child have any food allergies? ____

☐ ☐ Does your child have any persistent or intermittent skin rashes? __________________________

☐ ☐ Is your child taking any vitamins?

If yes, which ones? ____

TRAUMA: (Describe the trauma and the date that it occurred.)

☐ ☐ Has your child had any recent falls or trauma? ____

☐ ☐ Has your child ever fallen down stairs or fallen from any height? _________________________

☐ ☐ Has your child ever been in a motor vehicle collision or near miss? _______________________

☐ ☐ Has your child ever had a bone fracture or joint dislocation? ____________________________

☐ ☐ Has your child had any other trauma or injuries? ______________________________________

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?

____

GROWTH AND DEVELOPMENT:

☐ ☐ Can your child sit unsupported? At what age did your child start to sit-up? ____ mths

☐ ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

☐ ☐ Is your child walking yet? At what age did your child start to walk? _____mths

☐ ☐ Does your child often trip and fall? ____

☐ ☐ Do you have any other concerns about your child's growth and development? _______________

HEALTH HISTORY:

☐ ☐ Has your child had any upper respiratory infections? How often? ___________________________

☐ ☐ Has your child had asthma? ____

☐ ☐ Does your child ever complain of back or neck pain? ____________________________________

☐ ☐ Does your child ever complain of pains in the arms or legs? _______________________________

☐ ☐ Does your child ever complain of headaches? ____

☐ ☐ Has your child had any earaches?

At what age did the first earache occur? ____________________________________

How frequently does your child have earaches? ______________________________

Do the earaches tend to occur in the same ear? Right ☐ Left ☐ Both ☐

☐ ☐ Has your child had any other illnesses? (Please list each illness and its' approximate date)

____

☐ ☐ Is your child presently receiving any medications? ______________________________________

☐ ☐ Has your child ever been to a hospital/emergency room for evaluation/treatment?

____

☐ ☐ Has your child been vaccinated recently(date)?____

☐ ☐ Do you have any other concerns about your child's health? ______________________________