

Prenatal history:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Y N List: _____

Ultrasounds during pregnancy? Y N How many? _____

Medications during pregnancy? Y N List: _____

Cigarette/Alcohol/social drug use during pregnancy? Y N List: _____

Location of birth ___ Hospital ___ Birthing Center ___ Home

The Birth

Was ANY medical or pharmaceutical intervention used? (i.e. forceps, vacuum extraction, C- Section, medications, spinal block, epidural, etc.) Y N Please list if so:

Were there complications during the delivery process? (prolonged labor, baby positioned improperly, difficulty descending in birth canal, etc.) Y N Please list: _____

Birth Weight _____ Birth length _____ Apgar Score _____

Feeding history

Breast Fed Y N How long? _____ Any difficulties? Y N _____

Formula Fed Y N How long? _____ Type _____

Introduced to solids at _____ months. Dairy products at _____ months Wheat products at _____ months

Food sensitivities or allergies _____

Developmental History

At what age was your child able to:

_____ Respond to Sound _____ Respond to visual stimuli _____ Hold Head Up

_____ Cross Crawl _____ Sit Up _____ Walk Alone

Is your child involved in any sports? Y N Please list: _____

Has your child been in any car accidents Y N Please list: _____

Has your child visited the ER for any reason? Y N Please list: _____

Has your child had any other traumas? Y N Please explain _____

Has your child had any surgeries? Y N Please list _____

Has your child had any childhood diseases (like mumps, chicken pox, measles, etc.) Y N Please list

Do you vaccinate your child? Y N Only Some Has child had all vaccinations to date? Y N

Authorization For Care Of a Minor

I authorize this office and its doctors to examine my child, and render chiropractic care as deemed necessary.

Signed _____ Date: _____