Infant & Baby Health Questionnaire (0 - 12mo)

Personal Information:

Date: _____

Child's Name: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Gender: M F

Soc. Sec #: _____

Child's Home Phone No. ( ) _____

Mother's Name: _____

Mother's Cell Phone No. ( ) _____

Mother's E-mail: _____

Mother's Employer: _____

Work Phone: ( ) _____ Ext: _____

Father's Name: _____

Father's Cell Phone No. ( ) _____

Father's E-mail: _____

Work Phone: ( ) _____ Ext: _____

Number of Siblings: _____ Ages: _____

Referred By: _____

Interested in appointment reminders? O Email O Text

Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: ( ) _____ O Home O Cell

Office Phone: ( ) _____ Ext: _____

Pediatrician/PCP's Name: _____

Insurance Information:

Do you expect insurance to contribute to your baby's care? O Yes O No

Insured's Name: _____ DOB: _____

Relationship to Child: _____ Effective Date: _____

Insurance Company: _____

ID *or* Contract Number: _____

Group *or* FECA Number: _____

Phone Number: ( ) _____ Ext: _____

Adjuster *or* Contact Name: _____

Claims Address: _____

Lifestyle Information:

How would you rate you baby's ability to physically move without any limitations or restrictions?

O Excellent O Very Good O Good O Average O Poor

How do you rate your diet if nursing or the quality of the formula you are providing for your baby?

O Excellent O Very Good O Good O Average O Poor

How do you rate your awareness and effort to avoid environmental chemicals and toxins for your baby?

O Excellent O Very Good O Good O Average O Poor

How do you rate your baby's psychological and emotional environment? (Excellent = Little Stress, Poor = Very Stressful)

O Excellent O Very Good O Good O Average O Poor

On a scale (1 worst, 10 best) how would you rank your baby's overall health & wellness status thus far?

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

On a scale (1 least, 10 most) how would you rank your priority for your baby's health?

O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Subluxation Related Complaints:

The goal of your baby's chiropractic evaluation is to identify neurological stress and abnormal neuro-structural patterns called spinal subluxations. Although chiropractic care is not a treatment for any specific medical condition it is common for spinal subluxations to be directly or indirectly related to many of the following infant related conditions. Please check if your child has any of the following:

- O Asymmetrical Facial Features
- O Poor Eye Control / Movements
- O Head Tilt / Torticollis
- O Head Distortion/ Plagiocephaly
- O Ear Aches / Ear Infections
- O Colic / Excessive Crying / Irritability
- O GERD / Acid Reflux / Frequently Spits-up
- O Constipation / Diarrhea
- O Difficulty Nursing / Latching
- O Back Arching / Tension
- O Dislike of Tummy Time
- O Seizures / Neurological Ticks
- O Failure to Thrive
- O Abnormal Sleep Patterns
- O Skin Problem / Rash / Eczema
- O Intolerances to Formula / Foods in Nursing Mom's Diet

General Health:

Child's Name: _____ Date: _____

Diet History:

Was your baby breast fed? O Exclusively Breastfed O Previously Breastfed O Breastfed and Formula Fed

Formula Details (if Applicable): OMilk O Soy O Organic O Homemade O Special: _____

Supplements your baby takes directly: _____

Supplements mom takes if nursing: _____

Vaccinations History: O Up-to-Date O Partial O Delaying O Conscientious Objector O Concerned/Unknown

O Vaccine Reactions: _____

Pregnancy History:

Please provide us with information as it relates to your pregnancy with this child by checking all that apply:

- O Accident While Pregnant
- O Alcohol Consumption
- O Amniocentesis
- O Abnormal Fetal Position or Breech
- O Chemical Exposure
- O Frequent Ultrasounds: # _____
- O Genetic Testing
- O Gestational Diabetes
- O Group-B Strep Positive
- O Hypertension
- O Bacterial or Viral Infection
- O Yeast/Fungal Infection
- O Morning Sickness / Nausea
- O Placenta Abruptio
- O Placenta Previa
- O Poor Nutrition
- O Pre-Eclampsia
- O Prescription Medication
- O Radiation Exposure
- O Recreational Drug Use
- O Rhogam Injection
- O Swelling or Edema
- O Pre-Natal Vitamins
- O Unknown/Adopted

Birth & Labor History:

Birth Weight: _____

Birth Height: _____

Final APGAR: _____

Place of Birth: O Hospital O Birthing Center O Home

Birth Care Providers: O OB/Gyn O Midwife O Doula

Please check all that apply in regards to your labor and the birth process for this child:

- O Fetal Monitoring
- O Abnormal or Breech Presentation
- O Cord Around Neck
- O Labor Induced
- O Rupture of Membranes
- O Pitocin Administered
- O Long and/or Difficult Labor
- O Antibiotics Administered
- O Pain Medication
- O Epidural
- O Lack of Fetal Decent
- O Lack of Progression
- O Fetal Distress
- O Meconium
- O Forceps
- O Suction Device
- O Obstetrical Pulling
- O Cesarean Section

Post Natal History:

Choose all that apply for your baby as a newborn:

- O Resuscitation/Oxygen Required
- O Prolonged Cranial Distortion
- O Difficulty Nursing/Latching/Suckling
- O Meconium Aspiration/Stomach Pumped
- O Antibiotic Administered
- O Circumcised
- O Premature
- O Poor Sleeping
- O Jaundice
- O Low APGAR score
- O Failure to Thrive
- O Colic

Family History:

- O Arthritis
- O Cancer
- O Cardiovascular/ Heart Disease
- O Diabetes
- O Hypertension
- O Genetic Disorder
- O Unknown/ Adopted

Child's Name: _____ Date: _____

Infant Health History (ROS):

Constitutional:
- O Fever
- O Abnormal Tone
- O Recent Trauma
- O Irritability
- O High Pitched Crying
- O Poor Sleep
- O Poor Weight Gain
- O Weight Loss

EENT:
- O Excessive Tearing
- O Blocked Tear Duct
- O Conjunctivitis
- O Poor Eye Control
- O Poor Hearing
- O Ear Aches
- O Discharge from Ear
- O Poor Smell
- O Nasal Congestion
- O Difficulty Swallowing
- O Tongue Tied
- O Spots on Tongue
- O Thrush

Respiratory:
- O Difficulty Breathing
- O Shortness of Breath
- O Wheeze
- O Sputum
- O Cough

Genital:
- O Undescended Testes
- O Hydrocele
- O Testicular Torsion
- O Circumcision Concern
- O Gonadal Mass
- O Genital Rash
- O Vaginal Discharge
- O Breast Mass

Integumentary:
- O Jaundice
- O Skin Rash / Eczema
- O Diaper Rash
- O Bruises
- O Scars
- O Skin Masses/Bumps
- O Skin Color Changes

Musculoskeletal:
- O Swelling of Muscles/Joints
- O Limited Range of Motion
- O Fall from a High Surface

Neurological:
- O Seizures
- O Neurological Ticks
- O Convulsions
- O Tremors
- O Uncoordinated Movements

Cardiovascular:
- O Cyanosis (blue/purple color)
- O Cold Hands or Feet
- O Extremity Swelling
- O Abnormal Heart Rhythm

Immunological:
- O Food Intolerance
- O Environmental Intolerance
- O Allergy
- O Lymph Node Enlargement
- O Meningitis
- O Serious Infection

Gastrointestinal:
- O Bloating
- O Constipation
- O Diarrhea
- O Stomach Tenderness
- O Excessive Spitting-up
- O Vomiting
- O Lack of Nursing or Eating
- O Bloody Stools
- O Dark Tarry Stools
- O Rectal Rash

Endocrine:
- O Neck or Thyroid Mass
- O Abnormal Growth Patterns
- O Excessive Sweating

Urinary:
- O Difficult Urination
- O Foul Smelling Urine
- O Sweet Syrup Smelling Urine
- O Blood in Urine
- O Seemingly Painful Urination

Medical History:

*Please list any **Prescription Medications** your child takes:*

_____
_____
_____

*Please list any **Surgical Procedures** your child has had:*

_____
_____
_____

*Has your child ever needed any **Emergency Services**?*

_____
_____
_____

*List any known **Allergies** that your child currently has:*

_____
_____
_____

Minor Consent

Consent for Evaluation and Treatment of a Minor Child:

I hereby authorize the Doctor to treat my child's conditions as he/she deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary to my child"

Child's Name: _____

Parent/Guardian Name: _____

Guardian Signature: _____

Date: _____