NEWBORN HISTORY
Birth to 6 months

Today's Date: ___________________

Patient's Name:_______________________________ Sex: M F Date of Birth:_____________ Age:_______

BIRTH HISTORY

How long was the labor from the first regular contraction to the birth? ____________ hours

How long was the 2nd stage (the pushing phase) of the labor? _________________ hours

Yes	No		Yes	No		Yes	No	
☐	☐	Hospital Birth	☐	☐	Vaginal Delivery	☐	☐	Was birth induced (Pitocin)
☐	☐	Home Birth	☐	☐	Planned C-section	☐	☐	Forceps Delivery
☐	☐	Midwife Assisted	☐	☐	Emergency C-section	☐	☐	Vacuum Extraction
☐	☐	Anesthesia Administered	☐	☐	Head Presentation			
☐	☐	Fetal Distress	☐	☐	Face Presentation			
☐	☐	Meconium Staining	☐	☐	Breech Presentation			

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute ______ / 10 At 5 minutes _____/ 10

Baby's Crying: Baby cried immediately after birth:____

Cried strongly:_______ week cry:__________ did not cry for ________ minutes

Baby's Color: Pink all over:______ Blue face:__________ Blue hands/feet:______________

Baby's Activity: Arms and legs actively moving______________ Floppy baby_______________________

Intensive Care: Was required: Y N Days in Neonatal Intensive Care Unit:__________________________

Medication given at birth: _____________________________ Vaccines administered:__________________________

Birth weight:_____________ lbs/kgs Birth length:_____________ ins/cms Baby home on day:_____________

HEALTH HISTORY

Primary Complaint:____ Onset:______________

How many hours does your baby sleep between feedings? During day:________________ At night:________

Yes	No	
☐	☐	Does your baby go to sleep easily? ____
☐	☐	Does baby have a preferred sleeping position? ______________________________________
☐	☐	Does baby cry if you change this sleeping position? __________________________________
☐	☐	Does baby have any feeding difficulties? ____
☐	☐	Is baby being breast fed? ___________ If no, for how long was baby breast fed____________ weeks/ months
☐	☐	Does baby have a one sided breast-feeding preference? __________________ Preferred breast: Left / Right
☐	☐	Is baby formula fed? _________ Which formula or other milk source?__________________________
☐	☐	Does baby frequently spit-up after feeding?____
☐	☐	Does your baby cry a lot? For how many hours each day?__________________________________
☐	☐	Does baby pass a lot of intestinal gas?____
☐	☐	Does baby have a preferred head position?____
☐	☐	Does baby frequently arch his/her head and neck backwards? _____________________________
☐	☐	Does baby cry or become irritable during a diaper change? _______________________________
☐	☐	Has baby ever had a fever? ____
☐	☐	Has baby had any falls? ____
☐	☐	Has baby been in a car accident or near-miss? ____
☐	☐	Has baby had any other trauma? ____
☐	☐	Has your baby been vaccinated? ____
☐	☐	Do you have any other concerns you wish to discuss? ______________________________________

INFANT HISTORY
7 months to 3 years

Today's Date: ___________________

Patient's Name:___________________________________ Sex: M F Date of Birth:____________ Age:________

HEALTH HISTORY

Chief Complaint:____ Onset:______________

Yes	No	
☐	☐	Has your child had colic?_______________________________________
☐	☐	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? ______________________________
☐	☐	Does your child's earaches usually tend to occur in the same ear? Is it the: ☐ right ☐ left ☐ or both
☐	☐	How your child had any other illnesses? Please list each illness and its approximate date: ____________ ____
☐	☐	Is your child presently receiving any medication? ______________________________
☐	☐	Has your child ever been to a hospital or emergency room for evaluation or treatment?
☐	☐	Has your child recently been vaccinated?

NUTRITION

Yes	No	
☐	☐	Is your child still being breast fed? If no, for how long was he/she breast fed? ________________
		If still breast-feeding, 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 is your child's favorite food? ____________________
		What foods does his/her diet contain? ______________________________
☐	☐	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 receiving any vitamin supplements? ______________________________

TRAUMA

Yes	No	
☐	☐	Has your child had any recent falls or trauma? If yes, describe the trauma and the date it occurred?__________ ____
☐	☐	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

Yes	No	
☐	☐	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?______________ ____
☐	☐	Do you have any other concerns about your child's health?

Form#: CHINF3YRS-253

PRE-SCHOOL CHILD HISTORY

Today's Date:_________________ **3 years to 5 years**

Child's Name:___________ _____________________ Sex M F Date of Birth____________ Age______

HEALTH HISTORY

Well-child Exam ☐ Primary Complaint:____ Onset:__________

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur?________________________
Was onset: ☐ Sudden ☐ or Gradual Is problem: ☐ Constant ☐ or Intermittent

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

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

☐ ☐ Has your child previous had chiropractic care? Previous Chiropractor:_________________________

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

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

☐ ☐ Does your child ever complain of headaches? ____

☐ ☐ Has your child had asthma? ____

☐ ☐ Is your child allergic to anything? ____

☐ ☐ Are there any smokers in the child's home? ____

☐ ☐ Has your child had any earaches? At what age did the child's first earache occur:____ ________________
How frequently does your child have earaches? ____
In which ear do your child's earaches usually occur? ☐ Right ☐ Left ☐ Both

☐ ☐ Is your child presently taking any prescribed medication?____________________________________

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

Please list any other illness which has been a concern for your child.

Please list any surgeries your child has had

TRAUMA

☐ ☐ Has your child had any recent falls or trauma? Describe the trauma and the date if occurred_______________
____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?___________________

☐ ☐ Has your child ever fallen down stairs or fallen from a significant 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?___________________

NUTRITION

☐ ☐ Do you have any concerns about your child's diet?__ ____

☐ ☐ Does your child have any food allergies? ____

☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? ______________________________

☐ ☐ Does your child take vitamin supplements? ____

☐ ☐ Does your child eliminate stools each day? ____

For how many months was your child breast-fed? ____

What does your child usually eat for Breakfast? ____

What does your child usually eat for Lunch? ____

What does your child usually eat for Dinner? ____

What does your child usually ear for Snacks? ____

How much cow's milk does your child drink each day? ____

What is your child's favorite food? ____

What type of fast foods does your child like to eat? ____

SCHOOL-AGE CHILD HISTORY

Today's Date:__________________ **6 years and Older**

Child's Name:____________________________________ Sex M F Date of Birth______________ Age_______

Reason for today's visit:____

When did this problem first occur?____

Yes	No	
☐	☐	Have you ever had this problem before?____
☐	☐	Have you previously been treated for this problem? Doctors Name: ___________________________________
☐	☐	Have you previously been to a chiropractor? When: ____

ABOUT YOUR HEALTH

In the past year have you had any of the following.

☐	☐	Back or neck pain? ____
☐	☐	Pains in the legs or arms? ____
☐	☐	Headaches? ____
☐	☐	Asthma? ____
☐	☐	Allergies? ____
☐	☐	Earaches? ____
☐	☐	Falls from a bicycle, skateboard, scooter, rollerblades or similar? ______________________________
☐	☐	Do you ever have a problem with bedwetting? ____
☐	☐	Have you ever been in a motor vehicle accident? ______________________________________
☐	☐	Have you ever had any broken bones? ____
☐	☐	Have you ever had any surgeries? ____
☐	☐	Are you at present taking any medications?____
☐	☐	Do you have any other health problems? ____

ABOUT YOUR LIFESTYLE

What grade are you in at school?____

How do you carry your school books?____

How heavy is your school book bag?____

What sports do you play?____

What hobbies do you have?____

How many hours each day to you watch TV?____

How many hours each day do you spend using a computer?____

How often do you play video games?____

On average, how many hours sleep do you get each night?____

Are there any smokers in your family?____

Do you feel stressed out?____

Do you have trouble reading the board in class?____

Do you ever have blurred vision?____

Do you wear glasses or contact lenses?____

Do you sometimes get headaches when you read?____

What do you usually eat for Breakfast? ____

What do you usually eat for Lunch? ____

What do you usually eat for Dinner? ____

What snacks do you have after school? ____

What is your favorite food? ____

How much water do you drink each day?____

How many sodas or colas do you drink each day?____

How often do you eat fast food items? ____