PEDIATRIC HEALTH HISTORY FORM INFANT-2 YEARS OLD

Please fill out this form as completely and accurately as possible.

Today's Date___________________

PERSONAL DATA

Child's Name________________________________ Age __________ Date of Birth _______________ Sex at Birth __

Home Address_______________________________ City __________________ State______ Zip ___________

First Parent's Name ______________________________ Second Parent's Name ______________________________

First Parent Phone # (____) _______________________ Second Parent's Phone # (____) ______________________

Parent's E-mail address____________________________________ Parent's Occupation______________________

Would you like to be signed up for reminders? (circle one) NO EMAIL TEXT (cell phone provider _______)

Emergency Contact ______________________________________ Relationship to child ________________________

Pediatrian's name _____________________________________ Pediatrian's Phone # (____)___________________

Names and Ages of Child's Siblings:____

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Denette Family Chiropractic can address for your child?

____

Are these concerns affecting your child's quality of life? (Please circle only those applicable to your child)

Socialization:	Y	N	Sleep:	Y	N	Walking:	Y	N
Sitting:	Y	N	Playing :	Y	N	Eating:	Y	N

CHIROPRACTIC HISTORY

Has your child ever received Chiropractic care? ❑Y ❑ N Name of D.C.________________________________

How long under care? ❑ ______days ❑______weeks ❑______ months ❑ years_________

Date of last visit: ______________Why did you stop?____

____

PREGNANCY AND BIRTH

Name of Obstetrician/Midwife: ____

Were there any complications to the pregnancy? ____

Was Mom on any medications, prescription or over-the-counter? ❒ Yes ❒ No If yes, please explain: _________

____

How many ultrasounds were performed? ____

Where was the baby born? ❑ Home ❑ Hospital ❑ Birthing Center ❑ Other:________________ ❑ Transfer?

Birth Weight ____________________________ Length _________________________

Congential anomalies/Defects? ____

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how your baby was birthed. (If you do not know, please skip to next question)

❑ Home	❑ Natural	❑ Hospital	❑ Caesarian section	❑ Forceps
❑ Breech	❑ Cord around neck	❑ Prolonged labor	❑ Drug induced labor	❑ Vacuum Extraction

If the delivery was by Caesarian section, was it: ❒ Emergency ❒ Planned

Were there complications during the delivery? ____

How long was the labor? _____________________ How long was the delivery? ____________________

Medications used during labor or delivery: ____

INFANCY

Was your child vaccinated? ❒ Yes ❒ No If yes, did your child have a reaction? ❒ Yes ❒ No
If yes, what was the reaction that occurred? ____________________________________
Was there any use of medications during infancy? ❒ Yes ❒ No
If yes, which medications were used, and for what?____________________________________
How long was your baby on these medications?____________________________________

According to the Nation Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your infant? ❒ Yes ❒ No
If yes, please describe:____
____
Did the infant suffer any other traumas such as car accidents or abuse? ____________________________
____

Was your child breast fed? ❒ Yes ❒ No If yes, for how long? ___________
Did your child prefer one breast over another? ❒ Yes ❒ No Which breast? ❒ R ❒ L
Was your child formula fed? ❒ Yes ❒ No How long? _____________ Type: __________________
What month was your child introduced to solids? __________________
Does your child have any food/juice allergies or intolerances? ❒ Yes ❒ No List: __________________
____

Check if child has achieved the following milestones

❑ Fists clench
❑ Laughs (4 months)
❑ Sits unaided (6-8 months)
❑ 1st words (da) (6-8 months)
❑ Crawling (11 months)
❑ Holds cup (12 months)
❑ Names objects (15 months)
❑ Smiling/Coos (2 months)
❑ Pushes up (4 months)
❑ Reaches (6 months)
❑ Pulls to stand (9 months)
❑ Stands alone (12 months)
❑ Knows 2 words (12 months)
❑ Runs (18 months)
❑ Holding head up (3 months)
❑ Turns back to stomach (5 mo)
❑ Pincher grip (8 months)
❑ Points (10 months)
❑ Walks with support (12 months)
❑ Walks alone (15 months)
❑ Points to body parts (18 months)

The effects of subluxation can be broad and far reaching. They can show up as other health concerns. Please mark all conditions/symtoms your child has experienced:

❑ Seizures
❑ Ear/Sinus Infections
❑ Asthma
❑ Allergies & Congestion
❑ Failure to thrive
❑ Depression
❑ Reflux/GERD
❑ Chronic cough/colds
❑ Diabetes Mellitus Type __
❑ Bronchitis/Pneumonia
❑ Sensory/Spectrum D/O
❑ ADD/ADHD
❑ Focus/Memory Issues
❑ Anxiety/Stress
❑ Speech issues
❑ Diarrhea
❑ Back pain
❑ Kidney issues
❑ Knock Knees
❑ Scoliosis
❑ Jaundice
❑ Eczema
❑ Food Allergies
❑ Constipation
❑ Colic/Excessive Crying
❑ Immune Dedficiency
❑ Headaches/migraines
❑ Vision/hearing issues
❑ Low energy & Fatigue
❑ Toe in/out when walking

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Daniel Denette, D.C and Kristen Denette, D.C. permission to render care to my child. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature of Parent:________________________________ Today's Date____________