INFANT HISTORY FORM

Today's Date ______________________ ID#: __________________________

Name______________________________ Date of Birth _____/_____/______ Social Security # ________-______-__________

Address _____________________________________ City ____________________ State _______ Zip __________________

Phone (Home) _______________________ Mothers mobile: _____________________Fathers mobile: __________________

Mother________________________ DOB_____/_____/________Father ______________________DOB_____/_____/_______

Pediatrician/Family MD _________________________City & State __________________________ Last Visit: ____/____/____

Purpose of last visit ____

Birth Height: _______ Birth Weight: _______ Current Height: _______ Current Weight: _______ Age: _______

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? ____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other *(please explain)* _______________________________________

Insurance Company ____

PREGNANCY HISTORY:

Third Trimester Presentation: ______Vertex ______Breech ______Transverse ______Face/Brow

Type of Birth: ______Normal Vaginal ______Forceps ______Cesarean ______Suction Cap or Vacuum

Location: ______Home _______Hospital ________Birthing Center _______Other:____________________

Problems during Pregnancy: ____

Problems during Labor/Delivery: ____

Was there presence of: ______Jaundice? (Yellow) ________Cyanosis? (Blue) ________Congenital Anomalies/Defects?

*If yes, please explain*____

INFANT HISTORY:

Infant feeding: ______Breast ______Bottle If Bottle; which Formula? ___________________________________

Number of Hours sleep per night __________ Quality of Sleep: ______Good ______Fair ______Poor

List all **IMMUNIZATIONS** you child has had**:** ____

Has your child ever been treated at the emergency room? ________ If yes; please explain _______________________________

Has your child ever been hospitalized? _________ If yes; please explain ____

Has your child ever had any Surgeries? ________ If yes; please explain ____

Is your child currently on any medication? ________ If yes; please list: ____

AT WHAT AGE DID THE CHILD:

Respond to sound_________ Follow an object with his/her eyes_________ Hold heel up________

Sit Alone_________ Crawl________ Stand_________ Walk alone_________

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_________ Mumps_________ Measles_________ Rubella________

Whooping Cough_________ Other: ____

Patient Name: ____ **DOB:** ________________ **ID#:** ________________

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to___________________
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to___________________
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to___________________
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: ______________________
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: ______________________

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: ______________________

Has your child ever sustained an injury playing organized sports? _______ If yes; please explain__________________________

____

Has your child ever sustained an injury in an auto accident? _______ if yes; please explain________________________________

____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: ______________________

_____Pain/Discomfort; explain____

_____Injury; explain____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/______ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? ____
3. Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_______________________________
4. Any **medication taken** for this problem? No Yes: ____
5. Have you seen any **other doctors** for this problem? No Yes: ____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

I understand that I am directly and fully responsible to Beaverton Family Chiropractic, PC for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retained these films for a period of no less than seven (7) years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

____ ______________________________

Parent's or Legal Guardian's Signature Date

 Drs. Initials_______