Patient Name: _____ **Date:** _____

History Of Birth

Hospital/birthing center: □ Home □ Medical □ Midwife Name of OBGYN/Midwife: _____

Duration of Gestation: _____ weeks Duration of Birth: _____

Was birth assisted: □ Yes □ No If yes, How? □ Forceps □ Vacuum Extraction □ C-Section □ Induced labor

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____

Was the delivery normal? □ Yes □ No If no, what complications were there? _____

APGAR at birth: _____ APGAR after 5 minutes: _____ Birth Weight: _____Birth Length: _____

Growth and Development

Was the infant alert and responsive within 12 hours of the delivery? □ Yes □ No

If no, Explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____

Vocalize? _____ Sit alone? _____ Teeth? _____ Crawl? _____ Walk? _____

Do his/her sleeping patterns seem normal? □ Yes □ No If no, explain: _____

Describe any health problems that exist on the mother's side (e.g. cancer, diabetes, etc.):

_____

Father's side:

_____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors

Chemical Stressors

During pregnancy, did the mother: Smoke: □ Yes □ No Drink Alcohol: □ Yes □ No
Take drugs: □ Yes □ No If yes, what: _____ Take supplements/vitamins: □ Yes □ No
Become ill: □ Yes □ No If yes, how: _____

Receive ultrasound(s): □ Yes □ No If yes, how many: _____ Receive invasive procedures (i.e. amniocentesis, CVS) □ Yes □ No

Was the child breast fed? □ Yes □ No If yes, for how long? _____

At what age was: Formula introduced: _____ Brand: _____ Cow's milk: _____ years Solid foods: _____ years

How would you describe the child's bowel movements? Frequency: _____ Consistency: _____

Did your child receive vaccinations? □ Yes □ No If yes, which ones: _____

Did your child react to them? □ Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses and why?_____

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much: _____

Psychological stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behavior problems? □ Yes □ No

If yes, what: _____

Does the child have any difficulties sleeping? (e.g. night terrors, sleepwalking, etc.) □ Yes □ No

If yes, specify: _____

Does your child go to daycare? □ Yes □ No If yes: From what age: _____ Average amount of screen time per week? _____

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal

□ Fast or excessively long birth □ Respiratory depression □ Cord around neck

□ Other, please explain: _____

Any falls/accidents during pregnancy? □ Yes □ No Has child had any major falls since birth? □ Yes □ No

If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations since birth? □ Yes □ No If yes, please explain: _____

Does your child play sports? □ Yes □ No If yes, what sport(s): _____
Number of hours per week: _____ Age child began: _____ years

Weight of school backpack: _____ lbs Approximate hours spent at play per week: _____ hrs

Is there anything else you would like the doctor to know?

_____

_____

_____

_____

_____

_____