NEW ENGLAND CHIROPRACTIC

Peadiatric : 0-12 months

THANK YOU FOR TAKING THE TIME TO FILL IN THIS FORM:

CHILD'S NAME M / F DOB:

ADDRESS

PARENT/GUARDIANS NAME: RELATIONSHIP:

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PARENT PHONE: HOME: MOBILE:

PARENT EMAIL:

NAME OF PEDIATRICIAN/DOCTOR:

CURRENT CONCERN WITH YOUR CHILD

WHO CAN WE THANK FOR REFERRING YOU?

GENERAL HEALTH HISTORY: PLEASE CHECK YES OR NO FOR THE FOLLOWING:

PRENATAL (CONCEPTION TO BIRTH)
WHILE PREGNANT WITH THIS CHILD DID THE MOTHER:

Smoke ☐ YES ☐ NO Have a poor diet ☐ YES ☐ NO

Drink Alcohol ☐ YES ☐ NO Have high Blood Pressure ☐ YES ☐ NO

Have any falls or injuries ☐ YES ☐ NO Any other illness ☐ YES ☐ NO

If yes to the above, please describe _____

Any prescribed medication ☐ YES ☐ NO

Have x-rays or Ultrasounds ☐ YES ☐ NO, Number _____

Duration of the pregnancy in weeks _____ Age of mother at time of birth_____

Perinatal (Birth)

Place of Birth ☐ Home ☐ Hospital ☐ Birthing Centre Childs Weight at birth _____

Provider ☐ Midwife ☐ Medical doctor ☐ Other APGAR Score 1 min____ 5min____

Type of Birth ☐ Vaginal ☐ Caesarean Section

Use of Drugs During Birth ☐ YES ☐ NO Forceps or Vacuum Extraction ☐ YES ☐ NO

Was Labour Induced ☐ YES ☐ NO, If yes, for what reason _____

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NEONATAL

IMMEDIATELY AFTER BIRTH/DURING INFANCY DID ANY OF THE FOLLOWING OCCUR?

NEED FOR CHILD TO BE RESPIRATED ☐ YES ☐ NO

NEED FOR CHILD TO BE IN A HUMIDICRIB ☐ YES ☐ NO

ADMINISTERED MEDICATIONS ☐ YES ☐ NO TYPE _____

DIFFICULTY FEEDING/LATCHING/SUCKING ☐ YES ☐ NO

FALLS ONTO HEAD ☐ YES ☐ NO HEAD BANGING ☐ YES ☐ NO

RECENT ILLNESS ☐ YES ☐ NO SURGERY ☐ YES ☐ NO

FAILURE TO GROW/GAIN WEIGHT ☐ YES ☐ NO

DISRUPTED SLEEP PATTERNS ☐ YES ☐ NO

HOURS OF SLEEP PER NIGHT_____ LENGTH OF NAPS IN DAY _____

SPEECH OR LANGUAGE DIFFICULTIES ☐ YES ☐ NO

FOOD ALLERGIES ☐ YES ☐ NO IF YES, LIST_____

☐ BREAST FED UNTIL WHAT AGE_____

☐ FORMULA FED TYPE OF FORMULA_____

PLEASE CIRCLE ANY RELEVANT CONDITIONS BELOW

TEETH	EYES	HEARING	COUGHS/COLDS	HEADACHE
BACKACHE	GAS	COLIC	CONSTIPATION	DIARRHOEA
REFLUX	EAR ACHE	SKIN RASHES	FREQUENT URINATION	DIFFICULT URINATION
NAPPY RASH	FLAKING SCALP	HYPERACTIVE	UNDER ACTIVE	MUSCLE TONE
DEVELOPMENT DELAY				