Mascot Chiropractic Centre

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Infant/Child Information

Child's Name _____ Date _____

Date of Birth _____/_____/_____ Gender: Male Female

Address _____ Suburb _____ Postal Code _____

Home Ph _____ Business Ph _____ Mobile Ph _____

Parent(s) Names _____

Siblings' Names and Ages _____

Parents' E-mail Address _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Has your child ever seen a Chiropractor? If yes, Date of last visit: _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

Any ultrasounds or other radiation? ◯ Yes ◯ No

Invasive Procedures (Eg. Amniocentesis) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOUR

Was labour induced? ◯ Yes ◯ No

Duration of labour? _____

Duration of active (pushing stage) labour?_____

Did you receive any pain medication during labour ? ◯ No ◯ Yes. If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No Please explain:_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising ◯ Odd shaped head

◯ Stuck in birth canal ◯ Fast or excessively long birth

◯ Respiratory depression ◯ Cord around neck

Did your child spend any time in intensive care? ◯ No ◯ Yes If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your baby have a preferred sleeping position? ◯ Yes ◯ No _____

Does your baby prefer one sided breast-feeding position? ◯ Yes ◯ No _____

Does your baby spit up after feeding? ◯ Yes ◯ No _____

Any falls from couches, beds, change tables? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:

1. Type _____ When _____

2. Type _____ When _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Has your child ever had x-rays taken? ◯ No ◯ Yes When?_____

What area of your child's body:_____

CHEMICAL STRESS

Was/is child breast-fed? ◯ No ◯ Yes For how long? _____

At what age was:

Formula introduced? _____ Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ◯ Yes ◯ No_____

History of antibiotics? ◯ Yes ◯ No

If so, how many courses of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding? ◯ Yes ◯ No _____

Did mother and baby have difficulty bonding? ◯ Yes ◯ No _____

Did mother experience any post-partum depression? ◯ Yes ◯ No _____

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Behavior problems? ◯ Yes ◯ No _____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend day care? ◯ Yes ◯ No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain why:_____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

_____

On father's side:

_____

Does sibling's have any health concerns? ◯ Yes ◯ No

If yes, please describe: _____

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of _____

accept and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____