

CHILD HISTORY FORM



HISTORY OF BIRTH

| | | | | | |
|--|--|-----------------------------------|---------------------------------|------------------------|--|
| Please select one or more of the following: Hospital Birthing Center Home | | Delivery by: Midwife Ob/Gyn | | Duration of Gestation: | |
| Please select if any of the following applies: forceps, vacuum extraction, c-section, induced labor? | | | | | |
| Duration of Birth? | | | Complications at birth? Explain | | |
| Birth Weight | | Birth Length | | | |
| APGAR at Birth | | | After 5 minutes | | |

GROWTH AND DEVELOPMENT

| | | | | | |
|--|--|-------------------|----------|-----------|--|
| Was the infant alert and responsive within twelve hours of delivery? | | | Explain: | | |
| Please note N (Normal) or D (Delayed) for the following: | | | | | |
| Hold up head | | Vocalize | | Sit Alone | |
| Teethe | | Sleeping Patterns | | Crawl | |
| | | | | Walk | |
| Any health problems (cancer, diabetes, heart disease, etc) on the mother's side of the family? | | | | | |
| On the father's? | | | | | |
| With siblings? | | | | | |

Problems that chiropractors concern themselves with can be related to many types of stressors; the following is also very important to us.

CHEMICAL STRESSORS:

| | | | | | |
|--|--|------------------------------|-----------------------------------|----|--|
| During Pregnancy did the mother: | | | | | |
| Smoke | | Yes | | No | |
| Live with Smokers? | | Yes | | No | |
| Any smokers in the home? | | Yes | | No | |
| Have any invasive procedures? (amniocentesis, CVS) | | Have any illness? | | | |
| Any exposure to ultrasound? | | What was the medical reason? | | | |
| Take any nutritional supplements? Please list: | | | | | |
| Take any medications? Please list: | | | | | |
| About the BABY: | | | | | |
| Breast Fed? | | | How long? | | |
| Formula introduced at age: | | | Type of formula used: | | |
| Introduction to cow's milk at age: | | | Any colic, constipation, or gerd? | | |
| Age and type of solid baby food introduction: | | | Describe: | | |
| Any food or juice intolerance? | | | Describe: | | |
| Total number of courses of antibiotics to date: | | | | | |
| List all medications child has taken/is currently taking: | | | | | |
| Which vaccines has the child been given and please list any reactions: | | | | | |

Psychosocial Stressors:

| | | | | | | | |
|--|--|-----|--|---|--|----------|--|
| Any difficulties with lactation? | | Yes | | No | | Explain: | |
| Any problems with bonding? | | Yes | | No | | Explain: | |
| Any behavioral problems? | | Yes | | No | | Explain: | |
| Any night terrors or difficulty sleeping? | | Yes | | No | | Explain: | |
| Does your child seem normal for their age? | | Yes | | No | | Explain: | |
| Age of child when began daycare: | | | | Average number of hours of television/week: | | | |

Traumatic Stressors:

| | |
|--|--|
| Describe any traumas during pregnancy (falls, accidents)? | |
| Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around the neck, other? | |
| Any falls from couches, beds, change tables? | |
| Any traumas with bruising, cuts, stitches, fractures? | |
| Any hospitalizations, explain: | |
| Any surgeries or organs removed? | |
| Sports played and age began: | |
| Number of hours/week played: | |
| Weight of school backpack: | |
| Approx. hours spent at play per week: | |