



Infant & Baby Health Questionnaire (0 - 12mo)

Personal Information:

Date: _____

Child's Name: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Gender: M F

Soc. Sec #: _____

Child's Home Phone No. () _____

Mother's Name: _____

Mother's Cell Phone No. () _____

Mother's E-mail: _____

Mother's Employer: _____

Work Phone: () _____ Ext: _____

Father's Name: _____

Father's Cell Phone No. () _____

Father's E-mail: _____

Work Phone: () _____ Ext: _____

Number of Siblings: _____ Ages: _____

Referred By: _____

Interested in appointment reminders? ☐ Email ☐ Text

Insurance Information:

Do you expect insurance to contribute to your baby's care? ☐ Yes ☐ No

Insured's Name: _____ DOB: _____

Relationship to Child: _____ Effective Date: _____

Insurance Company: _____

ID or Contract Number: _____

Group or FECA Number: _____

Phone Number: () _____ Ext: _____

Adjuster or Contact Name: _____

Claims Address: _____

Lifestyle Information:

How would you rate your baby's ability to physically move without any limitations or restrictions?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

How do you rate your diet if nursing or the quality of the formula you are providing for your baby?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

How do you rate your awareness and effort to avoid environmental chemicals and toxins for your baby?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

How do you rate your baby's psychological and emotional environment? (Excellent = Little Stress, Poor = Very Stressful)

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

On a scale (1 worst, 10 best) how would you rank your baby's overall health & wellness status thus far?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On a scale (1 least, 10 most) how would you rank your priority for your baby's health?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Emergency Contact:

Name: _____

Relationship to Child: _____

Phone: () _____ ☐ Home ☐ Cell

Office Phone: () _____ Ext: _____

Pediatrician/PCP's Name: _____

Subluxation Related Complaints:

The goal of your baby's chiropractic evaluation is to identify neurological stress and abnormal neuro-structural patterns called spinal subluxations. Although chiropractic care is not a treatment for any specific medical condition it is common for spinal subluxations to be directly or indirectly related to many of the following infant related conditions. Please check if your child has any of the following:

- | | |
|--|---|
| ☐ Asymmetrical Facial Features | ☐ Difficulty Nursing / Latching |
| ☐ Poor Eye Control / Movements | ☐ Back Arching / Tension |
| ☐ Head Tilt / Torticollis | ☐ Dislike of Tummy Time |
| ☐ Head Distortion/ Plagiocephaly | ☐ Seizures / Neurological Ticks |
| ☐ Ear Aches / Ear Infections | ☐ Failure to Thrive |
| ☐ Colic / Excessive Crying / Irritability | ☐ Abnormal Sleep Patterns |
| ☐ GERD / Acid Reflux / Frequently Spits-up | ☐ Skin Problem / Rash / Eczema |
| ☐ Constipation / Diarrhea | ☐ Intolerances to Formula / Foods in Nursing Mom's Diet |

General Health:

Child's Name: _____ Date: _____

Diet History:

Was your baby breast fed? ☐ Exclusively Breastfed ☐ Previously Breastfed ☐ Breastfed and Formula Fed

Formula Details (if Applicable): ☐ Milk ☐ Soy ☐ Organic ☐ Homemade ☐ Special: _____

Supplements your baby takes directly: _____

Supplements mom takes if nursing: _____

Vaccinations History: ☐ Up-to-Date ☐ Partial ☐ Delaying ☐ Conscientious Objector ☐ Concerned/Unknown

☐ Vaccine Reactions: _____

Pregnancy History:

Please provide us with information as it relates to your pregnancy with this child by checking all that apply:

- | | | |
|---|--|---|
| ☐ Accident While Pregnant | ☐ Group-B Strep Positive | ☐ Pre-Eclampsia |
| ☐ Alcohol Consumption | ☐ Hypertension | ☐ Prescription Medication |
| ☐ Amniocentesis | ☐ Bacterial or Viral Infection | ☐ Radiation Exposure |
| ☐ Abnormal Fetal Position or Breech | ☐ Yeast/Fungal Infection | ☐ Recreational Drug Use |
| ☐ Chemical Exposure | ☐ Morning Sickness / Nausea | ☐ Rhogam Injection |
| ☐ Frequent Ultrasounds: # _____ | ☐ Placenta Abruptio | ☐ Swelling or Edema |
| ☐ Genetic Testing | ☐ Placenta Previa | ☐ Pre-Natal Vitamins |
| ☐ Gestational Diabetes | ☐ Poor Nutrition | ☐ Unknown/Adopted |

Birth & Labor History:

Birth Weight: _____ Place of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Height: _____ Birth Care Providers: ☐ OB/Gyn ☐ Midwife ☐ Doula

Final APGAR: _____

Please check all that apply in regards to your labor and the birth process for this child:

- | | | |
|---|---|---|
| ☐ Fetal Monitoring | ☐ Long and/or Difficult Labor | ☐ Fetal Distress |
| ☐ Abnormal or Breech Presentation | ☐ Antibiotics Administered | ☐ Meconium |
| ☐ Cord Around Neck | ☐ Pain Medication | ☐ Forceps |
| ☐ Labor Induced | ☐ Epidural | ☐ Suction Device |
| ☐ Rupture of Membranes | ☐ Lack of Fetal Decent | ☐ Obstetrical Pulling |
| ☐ Pitocin Administered | ☐ Lack of Progression | ☐ Cesarean Section |

Post Natal History:

Choose all that apply for your baby as a newborn:

- | | |
|--|---|
| ☐ Resuscitation/Oxygen Required | ☐ Premature |
| ☐ Prolonged Cranial Distortion | ☐ Poor Sleeping |
| ☐ Difficulty Nursing/Latching/Suckling | ☐ Jaundice |
| ☐ Meconium Aspiration/Stomach Pumped | ☐ Low APGAR score |
| ☐ Antibiotic Administered | ☐ Failure to Thrive |
| ☐ Circumcised | ☐ Colic |

Family History:

- ☐ Arthritis
- ☐ Cancer
- ☐ Cardiovascular/ Heart Disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Genetic Disorder
- ☐ Unknown/ Adopted

Infant Health History (ROS):

Constitutional:

- ☐ Fever
- ☐ Abnormal Tone
- ☐ Recent Trauma
- ☐ Irritability
- ☐ High Pitched Crying
- ☐ Poor Sleep
- ☐ Poor Weight Gain
- ☐ Weight Loss

EENT:

- ☐ Excessive Tearing
- ☐ Blocked Tear Duct
- ☐ Conjunctivitis
- ☐ Poor Eye Control
- ☐ Poor Hearing
- ☐ Ear Aches
- ☐ Discharge from Ear
- ☐ Poor Smell
- ☐ Nasal Congestion
- ☐ Difficulty Swallowing
- ☐ Tongue Tied
- ☐ Spots on Tongue
- ☐ Thrush

Respiratory:

- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Wheeze
- ☐ Sputum
- ☐ Cough

Genital:

- ☐ Undescended Testes
- ☐ Hydrocele
- ☐ Testicular Torsion
- ☐ Circumcision Concern
- ☐ Gonadal Mass
- ☐ Genital Rash
- ☐ Vaginal Discharge
- ☐ Breast Mass

Integumentary:

- ☐ Jaundice
- ☐ Skin Rash / Eczema
- ☐ Diaper Rash
- ☐ Bruises
- ☐ Scars
- ☐ Skin Masses/Bumps
- ☐ Skin Color Changes

Musculoskeletal:

- ☐ Swelling of Muscles/Joints
- ☐ Limited Range of Motion
- ☐ Fall from a High Surface

Neurological:

- ☐ Seizures
- ☐ Neurological Ticks
- ☐ Convulsions
- ☐ Tremors
- ☐ Uncoordinated Movements

Cardiovascular:

- ☐ Cyanosis (blue/purple color)
- ☐ Cold Hands or Feet
- ☐ Extremity Swelling
- ☐ Abnormal Heart Rhythm

Immunological:

- ☐ Food Intolerance
- ☐ Environmental Intolerance
- ☐ Allergy
- ☐ Lymph Node Enlargement
- ☐ Meningitis
- ☐ Serious Infection

Gastrointestinal:

- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach Tenderness
- ☐ Excessive Spitting-up
- ☐ Vomiting
- ☐ Lack of Nursing or Eating
- ☐ Bloody Stools
- ☐ Dark Tarry Stools
- ☐ Rectal Rash

Endocrine:

- ☐ Neck or Thyroid Mass
- ☐ Abnormal Growth Patterns
- ☐ Excessive Sweating

Urinary:

- ☐ Difficult Urination
- ☐ Foul Smelling Urine
- ☐ Sweet Syrup Smelling Urine
- ☐ Blood in Urine
- ☐ Seemingly Painful Urination

Child's Name: _____ Date: _____

Medical History:

Please list any **Prescription Medications** your child takes:

Please list any **Surgical Procedures** your child has had:

Has your child ever needed any **Emergency Services**?

List any known **Allergies** that your child currently has:

Minor Consent

Consent for Evaluation and Treatment of a Minor Child:

I hereby authorize the Doctor to treat my child's conditions as he/she deems appropriate through the use of chiropractic adjustments and related services. Furthermore, the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

"I hereby authorize the Doctor and whomever he/she may designate as his/her associate to administer chiropractic care as he/she deems necessary to my child"

Child's Name: _____

Parent/Guardian Name: _____

► Guardian Signature: _____

Date: _____