



Infant Health History

(Ages 0-1)

Name: _____ DOB: _____ Date: _____

Parent(s)/Guardian(s) Name(s): _____ Enrolled in Medicare/Medicare Advantage? Yes No

Chief Complaint: _____

How and when did it start? _____

What makes it better? _____ What makes it worse? _____

Has your child been treated for this condition before? Yes No If yes, by whom? _____

Is your child currently under a healthcare provider's care for any other problems? Yes No

Previous Chiropractic Care: Last visit? Reason? Duration of care? _____

Current Medications/Antibiotics/Supplements: _____

Past Medications/Antibiotics: _____

Hospital/ER Visits/Surgeries? _____

Other Injuries/Accidents: _____

Prenatal History

Complications During Pregnancy: (circle, if any)

Toxemia Diabetes Morning Sickness Heartburn Back Pain Headaches Other

Mother's Health/Nutrition: (circle one) Poor Good Excellent

Stress During Pregnancy: (rate 1-10) _____ Falls/Injuries/Accidents During Pregnancy: _____

Family History of: (circle, if any) Diabetes Heart/Cardio Problems Other _____

Complications During Delivery: (circle)

None C-Section Vacuum/Forceps Induced Epidural Fetal Distress Meconium Oxygen ICU

Birth Injuries: (list) _____

Birth Weight: _____ Birth Length: _____ APGAR: _____, _____

