

INFANT HISTORY

2 months to 2 years

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age _____

How did you hear about our office or website? (Please list where you've seen/heard about our office or what web search you used.) _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

NUTRITION

Yes No

Is your child still being breast fed? If no, for how long was he/she breast fed _____
If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes No

Is your child formula fed? Which formula or other milk source? _____

Yes No

Is your child eating solid food? What foods does his/her diet contain? _____
_____ What is your child's favorite food? _____

Yes No

Does baby have any feeding difficulties? _____

Yes No

Does your child have any digestive disturbances? _____

Yes No

Does your child have any food allergies? _____

Yes No

Does your child have any persistent or intermittent skin rashes _____

Yes No

Is your child receiving any vitamin supplements? _____

TRAUMA

Yes No

Has your child had any recent falls or trauma? Describe the trauma and the date it occurred

Yes No

Has your child ever fallen down stairs or fallen from any height? _____

Yes No

Has your child ever been in a motor vehicle collision or near-miss? _____

Yes No

Has your child ever had a bone fracture or joint dislocation? _____

Yes No

Has your child had any other trauma or injuries? _____

Yes No

Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

GROWTH AND DEVELOPMENT

Yes No

Can your child sit unsupported? At what age did you child start to sit up? _____

Yes No

Is your child crawling yet? At what age did your child start crawling? _____ months

Yes No

Is your child walking yet? At what age did your child start to walk? _____ months

Yes No

Does your child trip and fall? _____

Yes No

Do you have any other concerns about your child's growth and development? _____

HEALTH HISTORY

Yes No

Has your child had colic? _____

Yes No

Has your child had any upper respiratory infections? How often? _____

Yes No

Has your child had asthma? _____

Yes No

Does your child ever complain of back or neck pain? _____

Yes No

Does your child ever complain of pains in the arms or legs? _____

Yes No

Does your child ever complain of headaches? _____

Yes No

Has your child had any earaches? At what age did the first earache occur? _____

Yes No

How frequently does your child have earaches? _____

Yes No

Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? _____

Yes No

Has your child had any other illnesses? Please list each illness and its approximate date: _____

Yes No

Is your child presently receiving any medications? _____

Yes No

Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes No

Has your child recently been vaccinated? _____

Yes No

Do you have any other concerns about your child's health? _____