



INFANT-TODDLER HEALTH RECORD

ABOUT THE CHILD	
Patient Name:	
Address:	
City:	State/Zip Code:
Home/Cell Phone:	
Date of Birth:	Age:
Gender:	Weight:
Siblings (names and ages):	

MEDICATIONS/VACCINATIONS
Number of doses of prescription medication child has taken during his/her/their lifetime:
Please list all medication(s):
Have you chosen to vaccinate your child? <input type="checkbox"/> Yes. <input type="checkbox"/> No.
If yes, check all that your child has received: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other
Describe any and all reactions to vaccine(s):

ABOUT THE PARENTS	
Parents/Legal Guardians Names:	
Are you the parent or legal guardian? <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Address: <input type="checkbox"/> same as above	
Home Phone:	Cell Phone:
E-mail address:	

CHIROPRACTIC EXPERIENCE
Who referred you to our office?
Has any member of your family ever seen a chiropractor? <input type="checkbox"/> Yes. <input type="checkbox"/> No.

REASON FOR THIS VISIT

Describe the reason for this visit:

- Wellness Condition

If condition, describe:

The purpose of this appointment related to:

- sports auto fall home injury
 other

Please explain:

When did this condition begin?

Has this condition:

- Gotten worse Stayed constant
 Come and gone

Has this condition occurred before?

- Yes. No.

Please explain:

Have you seen other doctors/chiropractors for this condition?

- Yes. No.

Doctor's Name:

Type of treatment:

Results:

PRENATAL HISTORY

During pregnancy, did you use:

- drugs/medications tobacco/alcohol

If yes, please list:

Location of birth:

- Home Birthing Center Hospital

Describe your delivery:

- Labor was chemically induced.
 Labor was doctor assisted.
 C-section delivery
 Forceps/vacuum extraction
 Doctor pulled or twisted baby

Please explain:

Due date: _____

Actual birthday: _____

Describe any complications experienced during delivery:

Did you experience any illness(s) while pregnant?

- Yes. No.

Please explain:

Please describe any genetic or disabilities.

Birth weight:

Birth Length:

Apgar Scores:

Ultrasound during pregnancy?

- Yes. No. Number: _____

PRENATAL HISTORY CONTINUED

Did you breastfeed the baby?

Yes. No.

If yes, how long?

At what age did you introduce:

- Solids:

- Cow's milk:

Are you aware of any food or juice allergies or intolerance?

Yes. No.

LIFESTYLE HABITS

Does your child take vitamins? Yes. No.

Does your child interact with technology (tablet, phone, TV, etc.) more than one hour per day? Yes. No.

How much?

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.*

acid reflux

constipation

frequent colds, coughs, etc.

asthma

diarrhea

hyperactivity

bed wetting

difficult weight gain

learning disorders

colic

ear infections

sleeping difficulties

CURRENT HEALTH HISTORY

The national safety council reports approximately 50% of children fall head first from a high place (i.e.: bed, changing table, stairs, etc.) during first year of life.

Was this the case for your child? Yes. No.

Please explain:

Has your child ever been hospitalized or had surgery?

Yes. No.

Please explain:

Has your child ever been in a car accident?

Yes. No.

Please explain:

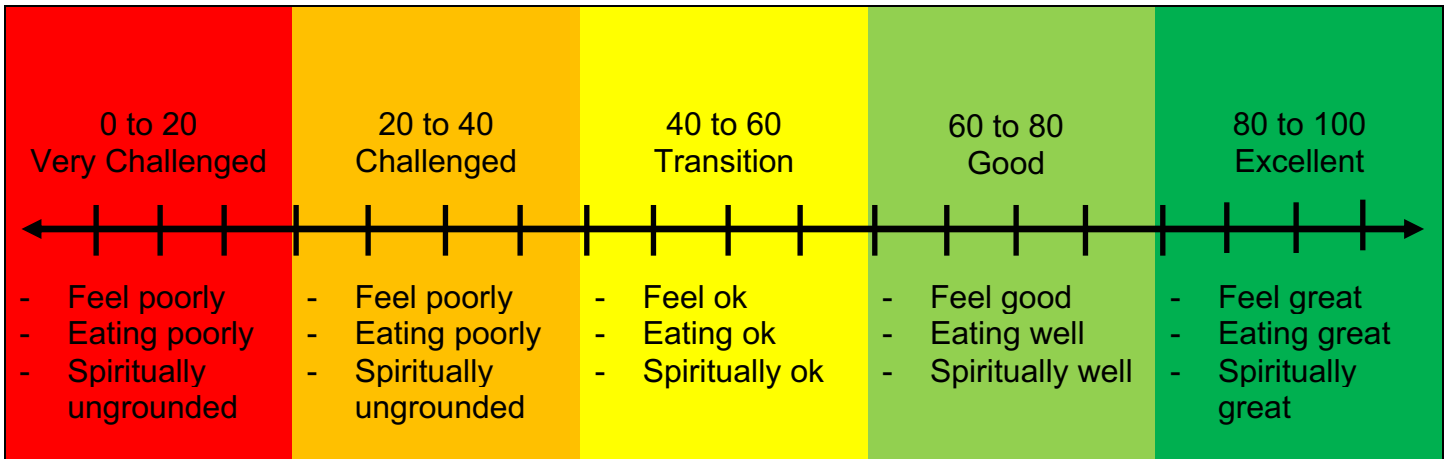
Does your child have difficulty interacting with others?

Yes. No.

Please explain:

CHILD'S HEALTH:

Circle the segment of the line that indicates where you believe your child's health and wellness is at this time. Place an "x" on the line where you would like your child's health and wellness to be.



AUTHORIZATION FOR CARE OF A MINOR

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I authorize the doctor to share relevant health information with my physician.

Parent or Guardian Authorizing Care Signature:

Date: