Infant Case History – (Birth - 2 Years)

Please complete the following in as much detail as possible. Your answers will allow us to determine how best to care for your child.

Personal Information

Last Name: _____ First Name: _____ Middle Initial _____

Parents'/Guardians' Names: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Age: _____ Date of Birth: _____ (Month/Day/Year)

Medical Doctor: _____ Care Card Number: _____

What are your child's primary health challenges? _____

What are your goals once these challenges have been addressed? _____

Which other health professionals have you consulted regarding your child's health challenges?

_____

Who may we thank for your referral to our office? _____

Prenatal History

Complications during pregnancy: _____

Duration of pregnancy: _____ weeks Name of Doctor/Midwife _____

Please list any medications used during your pregnancy: _____

Labour and Delivery History

Was your labour (please circle): Spontaneous Induced

Was your labour unusually long? ☐ Yes ☐ No

Was your pushing phase unusually long? ☐ Yes ☐ No

Were any medications used during your labour? ☐ Yes ☐ No

Interventions used during delivery: ☐ Forceps ☐ Suction ☐ Heavy Manual Traction

If you had a C-section, was it: ☐ Emergency OR ☐ Non-Emergency

[Continued on reverse]

Health History

In the past six months, has your baby experienced:

- ☐ Allergies
- ☐ Bowel Difficulties
- ☐ Colds (more than normal)
- ☐ Colic
- ☐ Ear Infections
- ☐ Food Sensitivities
- ☐ Fussiness/Difficult to Settle
- ☐ Gassiness
- ☐ Head Positioning Difficulties
- ☐ Pain/Discomfort
- ☐ Sleep Difficulties
- ☐ Vaccine Reactions

Was your child breastfed? ☐ Yes ☐ No (If yes, for how long?) _____

At what age did your child start solids? _____

At what age did your child commence with vaccinations? _____

Has your child ever had any of the following after vaccination?

☐ Behavior change ☐ Irritability ☐ High Fever ☐ Seizure

Developmental Milestones

At what age did your baby:

Hold up head _____ Sit independently _____ Crawl _____

Pull up to standing _____ Start walking _____

Have there been any problems with gait/walking? _____

Did your child use any of the following:

☐ Bumbo Chair ☐ Jolly Jumper ☐ Stabilized Exersaucer ☐ Unstabilized Exersaucer

Trauma History

Has your child ever:

- ☐ Fallen from a height
- ☐ Been in a motor vehicle accident
- ☐ Fallen from a moving object
- ☐ Experienced physical/sexual abuse
- ☐ Fallen down the stairs
- ☐ Broken any bones
- ☐ Experienced any other trauma _____

Is there anything else you would like us to know about your child? _____

_____

_____

Health Information:

What are your objectives in seeking chiropractic care? (please check all that apply)

- ☐ Relief of symptoms
- ☐ Improve sleep regulation
- ☐ Decrease the risk of symptoms returning
- ☐ Improve overall health and well being
- ☐ Improve mobility
- ☐ Other (please list) _____
- ☐ Improve nerve function

_____