



Infant & Baby Health Questionnaire (0 - 12mo)

Insurance Information:

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

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 you 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:

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

General Health:

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:

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

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

Post Natal History:

Choose all that apply for your baby as a newborn:

- | | |
|--|---|
| <input type="radio"/> Resuscitation/Oxygen Required | <input type="radio"/> Premature |
| <input type="radio"/> Prolonged Cranial Distortion | <input type="radio"/> Poor Sleeping |
| <input type="radio"/> Difficulty Nursing/Latching/Suckling | <input type="radio"/> Jaundice |
| <input type="radio"/> Meconium Aspiration/Stomach Pumped | <input type="radio"/> Low APGAR score |
| <input type="radio"/> Antibiotic Administered | <input type="radio"/> Failure to Thrive |
| <input type="radio"/> Circumcised | <input type="radio"/> 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

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: _____