Birth History

Labor and Delivery

How long was the labor from the first regular contractions to the birth?_____ Hours
How long was the 2nd stage (the pushing phase) of the labor?_____ Hours

Please checkmark all those that apply:

Hospital birth_____
Home birth_____
Midwife assisted_____

Vaginal Delivery_____
Planned C-section_____
Emergency C-section_____

Was birth induced (Pitocin)_____
Forceps delivery_____
Vacuum extraction_____

Anesthesia administered_____
Fetal distress_____
Meconium staining_____

Head presentation_____
Face presentation_____
Breech presentation_____

Baby's condition immediately after birth:
Apgar Scores: At 1 minute_____/10 At 5 minutes_____/10

Baby's crying: Baby cried immediately after birth_____
Cried strongly _____ Weak cry _____ Did not cry for _____ minutes

Baby's Color: Pink _____ Blue face _____ Blue hands/feet _____

Baby's Activity: Arms and legs actively moving _____ Floppy baby _____

Intensive care: Was required _____ Days in Neonatal Intensive Care Unit _____
Medication given at birth? _____
Birth weight _____lbs Birth length _____ in Baby home on day_____

Newborn History
Birth to 2 months

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

Yes No

- ☐ ☑ Does baby go to sleep easily?
- ☐ ☐ Does baby have a preferred sleeping position? _____
- ☐ ☐ Does baby cry if you change this sleeping position? _____
- ☐ ☐ Does baby have any feeding difficulties?
- ☐ ☐ Is baby being breast fed? If no, for how long was baby breast fed _____ Weeks/Months
- ☐ ☐ Does baby have a one sided breast-feeding preference? Preferred breast Left/Right
- ☐ ☐ Is baby formula fed? Which formula or other milk source? _____
- ☐ ☐ Does baby frequently spit-up after feeding?
- ☐ ☐ Does baby cry a lot? How many hours each day? _____
- ☐ ☐ Does baby pass a lot of intestinal gas?
- ☐ ☐ Does baby have a preferred head position?
- ☐ ☐ Does baby frequently arch his/her head and neck backwards?
- ☐ ☐ Does baby cry or become irritable during diaper change?
- ☐ ☐ Has baby ever had a fever? _____
- ☐ ☐ Has baby had any falls? _____
- ☐ ☐ Has baby been in a car accident or near-miss? _____
- ☐ ☐ Has baby had any other trauma? _____
- ☐ ☐ Has baby been vaccinated?
- ☐ ☐ Do you have any other concerns you wish to discuss?

_____

_____

_____

Newborn History
2 month to 2 years

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

Nutrition

☐ ☐ Is your child being breast fed? If no, how long was he/she breast fed? _____ Weeks/Months

☐ ☐ If still breast feeding, how much cow's milk does the mother consume each day?

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

☐ ☐ Is your child eating solid food? What foods does his/her diet contain?

☐ ☐ What is your child's favorite food?

☐ ☐ Does your child have any feeding difficulties?

☐ ☐ Does your child have any digestive disturbances?

☐ ☐ Does your child have any food allergies?

☐ ☐ Does your child have any persistent or intermittent skin rashes?

☐ ☐ Is your child receiving any vitamin supplements?

Trauma

☐ ☐ Has your child have any recent falls or trauma?

☐ ☐ Describe the trauma and the date it occurred:

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

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

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

☐ ☐ Has your child had any other trauma or injuries?

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

Pre-School Child History
3 years to 5 years

Reason for today's visit:_____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur?_____

Was onset… ☐ Sudden ☐ Gradual

Is problem… ☐ Constant ☐ Intermittent

☐ ☐ Has your child ever had this problem before?_____

☐ ☐ Has your child previously been treated for this problem? By whom?_____

☐ ☐ Has your child previously had chiropractic care? Previous chiropractor _____

☐ ☐ **Health History**

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

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

☐ ☐ Does your child ever complain of headaches?_____

☐ ☐ Has your child had asthma?_____

☐ ☐ Is your child allergic to anything?_____

☐ ☐ Are there any smokers in the child's home?_____

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

☐ ☐ How frequently does your child have earaches?_____

☐ ☐ In which ear do your child's earaches usually occur?_____

☐ ☐ Is your child presently taking an prescribed medication?_____

Please list any other illness which have been a concern for your child._____

_____

Please list any surgeries your child has had _____

_____

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

_____

School –Age Child History

6 years and older

About your lifestyle

What grade are you in at school?_____

How do you carry your school books?_____

How heavy is your school book bag?_____

What hobbies do you have?_____

How many hours each day do you watch tv?_____

How many hours each day do you spend using a computer?_____

How often do you play video games?_____

On average, how many hours of sleep do you get each night?_____

Are there any smokers in your family?_____

Do you feel stressed out?_____

Do you have trouble reading the board in class?_____

Do you ever have blurred vision?_____

Do you wear glasses or contact lenses?_____

Do you sometimes get headaches when you read?_____

About your diet

What do you usually eat for breakfast?_____

What do you usually eat for lunch?_____

What do you usually eat for dinner?_____

What snacks do you have after school?_____

What is your favorite food?_____

How much water do you drink each day?_____

How many sodas or colas do you drink each day?_____

How often do you eat fast food items?_____