

Gardiner Family Chiropractic
Child History Form

Name: _____ Date: _____

General Information

Was the child born: at home in a hospital midwife present
Were any fertility treatments used for conception? no yes What: _____
Was ultrasound used during pregnancy? no yes How many: _____
Were there any invasive procedures during pregnancy such as amniocentesis or CVS?
no yes What type? _____
Duration of Gestation: _____ weeks
Medical assistance used: forceps vacuum extraction c-section induction
Complications at birth: _____
APGAR at birth: _____ 5 minute APGAR: _____ Weight: _____ Length: _____

Growth and Development

Was the infant alert and responsive within 12 hours of birth? yes no
Explain: _____
At what age did the child achieve the following milestones:
Respond to sound _____ Follow an object visually _____ Hold up head _____
Vocalize _____ Sit alone _____ Begin teething _____
Crawl _____ Walk _____
Do the child's sleeping patterns seem normal to you? yes no
Explain: _____

Chemical Stressors

During pregnancy did mom smoke? no yes
During pregnancy did mom drink alcohol? no yes
During pregnancy did mom use any street drugs? no yes What: _____
Was mom ill at all during the pregnancy? no yes
Explain: _____
Was mom taking any medications or nutritional supplements during pregnancy?
no yes What kind? _____
Was the child breast fed? no yes How Long? _____
At what age was formula introduced? _____ Type of formula used: _____
Introduction of cow's milk at what age? _____ Began solid foods at age _____
Does the child exhibit any food intolerances? no yes What type? _____
Are there any pets in the home? no yes What kinds? _____
Is the child exposed to anyone who smokes, even if they do not smoke around the child?
no yes
Has the child needed to take any antibiotics? no yes How many courses? _____

Name: _____ Date: _____

We understand and support the fact that not all parents choose to vaccinate their children or do not follow the "recommended" vaccination schedule.

Has your child been vaccinated? no yes

Which vaccinations? _____

Any alteration from the "recommended" vaccination schedule? no yes

Explain: _____

Any adverse reactions? _____

Psychosocial Stressors

Did the child have any difficulties with lactation? no yes

Did the child have any problems with bonding? no yes

Has the child exhibited any behavioral problems? no yes

Explain: _____

Has the child had any difficulty sleeping, night terrors, or sleepwalking? no yes

Explain: _____

Is the child in daycare? no yes Age began: _____ Hours per week: _____

Traumatic Stressors

Was there any trauma (falls, accidents) to mom during pregnancy? no yes

Explain: _____

Was there any evidence of birth trauma (bruises, odd head shape, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck)? no yes

Explain: _____

Has the child fallen from a bed, couch, changing table, etc? no yes

Explain: _____

Has the child had any trauma resulting in bruises, cuts, or fractures? no yes

Explain: _____

Has the child ever been hospitalized? no yes

Explain: _____

List any sports that the child plays, age they started, and approximate hours per week.

Does the child carry a backpack? no yes Weight of backpack: _____

Do you have any specific concerns about your child or chiropractic that you would like addressed? no yes _____

Signature of Parent/Guardian _____ Date _____

Print name of Parent/Guardian _____

Relationship to Child _____