

Prenatal History:

Please list any complications during the pregnancy:

How many ultrasounds did you receive during your pregnancy?

Did you smoke, drink, or use drugs during your pregnancy?

Where was your child born (hospital, home, etc.)?

Please check all of the interventions used during the birth of your child:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Forceps | <input type="checkbox"/> C-Section | <input type="checkbox"/> Epidural |
| <input type="checkbox"/> Vacuum
Extraction | <input type="checkbox"/> Induced
Labor | <input type="checkbox"/> Other_____ |

Please list any complications during delivery: _____

Birth weight: _____ Birth length: _____ APGAR Score: _____

Was your child born with any genetic disorders/disabilities?

Feeding History:

Was your child breast-fed or bottle-fed (how long)? _____

Are you aware of any food allergies? _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

- | | |
|------------------------------------|-------------------|
| _____ Respond to sound | _____ Sit up |
| _____ Respond to visual
stimuli | _____ Cross Crawl |
| _____ Hold head up | _____ Stand alone |
| | _____ Walk alone |

Would you consider your child to be developing at a "normal" rate?

Yes/No

If no, please explain:

According to the National Safety Council, 50% of children fall head-first.

Has this happened to your knowledge? Yes/No

Please list any impact sports that your child is/has been involved in (soccer, football, gymnastics, trampoline, cheerleading, diving, etc.):

Please list any car accidents, emergency room visits, surgeries, traumas, concussions, illnesses etc. that your child has been through:

Has your child had:

- | | | |
|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Whooping cough | _____ |
| <input type="checkbox"/> Rubeola | | |

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature

Date