FAMILY CHIROPRACTIC CENTER, LTD.

Infant Form: Birth to Age 2

Date: _____

Child's Name _____ Date of Birth _____

Mother's Name _____ Occupation _____

Father's Name _____ Occupation _____

Address _____ Zip Code _____

Telephone (Home) _____ Telephone (Work) _____

Telephone (Mobile) _____ E-Mail Address _____

Can we text your appointment reminders? ☐ Yes ☐ No *(Please be sure you have provided a cell phone number.)*

Pediatrician's Name _____

Address _____ Phone Number _____

Names & ages of siblings _____

_____

How did you hear about Chiropractic/ this clinic? _____

Present Complaint _____

Have you consulted anyone else? _____

Has your baby had any ☐ medical treatment/ ☐ scans / ☐ x-rays / ☐ surgery?

Are you or your baby on any medication? _____

Was your baby born with any congenital disorder? _____

Is there any family history of illness? _____

Has your baby had vaccinations? ☐ Yes ☐ No ☐ Per Schedule? ☐ Alternate Schedule?

If yes, has your baby had any reactions to vaccinations? _____

Has your baby had any childhood illnesses? _____ Any known allergies? _____

Are there any feeding difficulties? _____

Is/was the baby on ☐ Bottle ☐ Breast ☐ Both

When was your baby weaned (if applicable) _____ Any trouble breastfeeding? _____

Any reflux/vomiting? _____ ☐ a little ☐ a lot ☐ projectile

Sleep well? _____ Use a pacifier? _____

Constant crying? _____ Regular bowel movements? _____

How many wet diapers a day? _____

FAMILY CHIROPRACTIC CENTER, LTD.

Infant Form: Birth to Age 2

Date: _____

PRENATAL / BIRTH

Any maternal illness or drugs during pregnancy? _____

Number of previous pregnancies _____ Number of ultrasound scans? _____

Duration of birth (from onset of labor) _____ 2nd stage _____

Length at birth _____ Weight at birth _____

Head circumference _____ APGAR Score _____

Was the Birth:

- ☐ Premature
- ☐ Induced Breech
- ☐ Due date
- ☐ Overdue by _____ days/week
- ☐ Forceps
- ☐ Vacuum
- ☐ Face or forehead presentation

If Caesarean: ☐ Planned ☐ Emergency

Did the Baby Have:

- ☐ Bruising
- ☐ Jaundice
- ☐ Special Care

Milestones:

Check if achieved / leave unchecked if not achieved yet

- ☐ 6 weeks **smiling**
- ☐ 3 months **head steady**
- ☐ 7 months **sits unaided**
- ☐ 9 months **stands unsupported**
- ☐ 11 months **crawling**
- ☐ 12 months **2 or 3 recognizable words**
- ☐ 14 months **walks unaided**
- ☐ 16 months **holds and drinks from a cup**

CHILD CONSENT

I hereby authorize and consent for my child _____ to be evaluated and treated by Dr. Bridget Horan, using chiropractic methods. The clinical procedures performed are gentle and usually beneficial. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not provide specific healthcare if she is aware that such care may be contraindicated. It is the responsibility of the patient's parent/guardian to inform the doctor of any and all health conditions by sharing a detailed health history, in its entirety.

(signature)

Parent / Guardian _____
(Print Name)

Signed _____ **Date** _____