newborn - toddler health record

ABOUT THE BABY

NAME	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

ABOUT THE PARENTS

MOTHER'S NAME:	
MOTHER'S ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
FATHER'S NAME:	
FATHER'S ADDRESS: (If different from above)	
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	

PHYSICIAN HISTORY

INSTRUCTIONS: *Please check if they have received the following:*

NAME and CONTACT INFORMATION FOR PEDIATRICIAN:

NAME and CONTACT INFORMATION FOR ANY OTHER PHYSICIANS:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAS YOUR CHILD EVER BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?

○ YES ○ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANYONE IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

ARE YOU INTERESTED IN ENHANCING THE HEALTH OF THE ENTIRE FAMILY?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

○ WELLNESS ○ AUTO ○ FALL ○ INJURY ○ OTHER

PLEASE EXPLAIN:

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:

○ GOTTEN WORSE ○ STAYED THE SAME ○ GOTTEN BETTER

DOES THIS CONDITION INTERFERE WITH:

○ SCHOOL ○ SLEEP ○ DAILY ROUTINE ○ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? ○ YES ○ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?

○ YES ○ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

medical history

PREGNANCY & LABOR

WERE THERE ANY COMPLICATIONS TO THE PREGNANCY?

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT? ○ YES ○ NO

PLEASE EXPLAIN:

DURING PREGNANCY DID YOU USE:

○ PRESCRIPTIONS/OTC DRUGS ○ ALCOHOL ○ TOBACCO (or father)

DESCRIBE THE DELIVERY:

○ LABOR CHEMICALLY INDUCED
○ LABOR WAS DOCTOR ASSISTED
○ C-SECTION DELIVERY
○ FORCEPS/VACUUM EXTRACTION
○ DOCTOR PULLED OR TWISTED BABY
○ PREMATURE DELIVERY
○ EPIDURAL ADMINISTERED
○ MIDWIFE or DOULA PRESENT

PLEASE EXPLAIN:

LENGTH OF DELIVERY

PRESENTATION AT BIRTH

VACCINATIONS AT BIRTH

WEIGHT AT BIRTH	**HEIGHT AT BIRTH**

NUTRITIONAL OVERVIEW

INSTRUCTIONS: *Please check if they have received any of the following:*

❑ COW'S MILK	❑ SOY MILK	❑ GOAT'S MILK
❑ RAW MILK	❑ JUICE: Fruit	❑ JUICE: Vegetable

❑ SOLID FOODS When were they introduced?

What was first introduced?

❑ MEDICATIONS
Please list.

❑ SUPPLEMENTS
Please list.

AFTER BIRTH

ANY ISSUES OR ILLNESS(S) AFTER BIRTH? ○ YES ○ NO

PLEASE EXPLAIN:

WHERE DID/DOES BABY SLEEP?

○ IN ROOM WITH MOM
○ IN SEPARATE ROOM
○ CO-SLEEPING
○ CRIB SLEEPING

SLEEPING DIFFICULTIES ○ YES ○ NO

PLEASE EXPLAIN:

❑ **BREASTFED** (How long?)

❑ **FEEDING PROBLEMS**

○ ONE SIDE ○ BOTH SIDES ○ LATCHING

❑ **FORMULA** (What kind?)

❑ **COLIC**	❑ **MIS-SHAPEN HEAD**
❑ **FAVOR OR ONLY TURN HEAD TO ONE SIDE**	❑ **ONLY USES ONE ARM OR HAND**

GENERAL HEALTH HISTORY

INSTRUCTIONS: *Please check each condition that your child has ever experienced.*

○ ALLERGIES	○ CONSTIPATION	○ IRRITABILITY
○ ASTHMA	○ DIGESTIVE PROBLEMS	○ SKIN PROBLEMS
○ BREATHING PROBLEMS	○ EAR PROBLEMS	○ SLEEPING ISSUES
○ CIRCUMCISION	○ FREQUENT COLDS	○ TUBES IN THE EARS
○ COLIC		

○ PERSISTENT CRYING (How often?)

○ DELAYED LANGUAGE DEVELOPMENT

○ CRAWLING? If so, when?

○ WALKING? If so, when?

○ OTHER:

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ○ YES ○ NO	**DID YOU OPT FOR A DELAYED SCHEDULE?** ○ YES ○ NO	**HAVE YOU OPTED FOR MERCURY-FREE VACCINES?** ○ YES ○ NO

CHECK IF YOUR CHILD HAS RECEIVED THE FOLLOWINGVACCINATION(S):

○ VITAMIN K ○ HEPATITIS B ○ HEPATITIS A ○ ROTAVIRUS ○ DTap ○ MMR ○ CHICKEN POX

○ PNEUMOCOCCAL ○ GARDASIL ○ INACTIVATED POLIO ○ MENINGITIS ○ H1N1 ○ FLU ○ COVID

○ OTHER ______________________________

DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

authorizations and releases

TERMS OF ACCEPTANCE	
When a patient seeks holistic care and we accept a patient for care, it is essential for both to be working towards the same objective. Our office has only one goal—to improve the function of the human body. I will alert the doctor and/or staff if I do not understand or accept part of treatment. *I hereby authorize the Doctor to work with my condition through the use of chiropractic adjustments, nutritional supplements, massages, exercises and/or other therapies, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.*	
SIGNATURE OF PARENT OR GUARDIAN:	DATE:
PRINTED NAME OF PARENT OR GUARDIAN:	

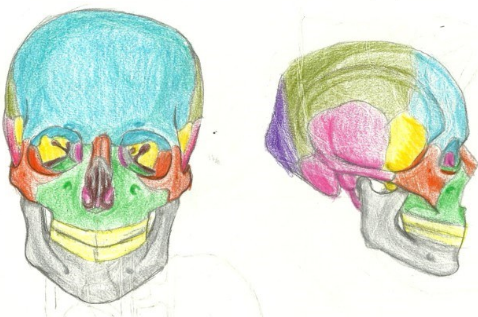
in-office evaluation

**** FOR OFFICE USE ONLY ** TO BE COMPLETED BY DOCTOR ****

HEAD MEASUREMENT: INV SWING:

Age	Fine Motor		Gross Motor		Adaptive	
1 MO			Good upright head control		Occasional eye following	
2 MOS	Smiles		Head up when prone		Eyes follow regularly	
3 MOS	Opens hands; Grasps at objects ANTERIOR FONTANELLE		Assumes portion of body wt with arms when prone		Looks at objects in hand; Babbles	
6 MOS	Uses hands in raking motion		Rolling over for several mos		Transfers from hand to hand	
9 MOS	Picks up objects using fingers & thumb		Sits unsupported		Successfully picks up toys	
12 MOS	Well developed pincer grasp		Crawling; Stands unsupported		Feeds from cup unassisted	
18 MOS	Turns pages one at a time		Walks with minimal assistance		Holds own bottle unassisted; Feeds self with utensils	

CRANIAL PATTERNS | IMBALANCES



Primitive Reflex	Vanish	Age/Date
GALANTS	2 Mos	
MORO	3 Mos	
PEREZ	3 Mos	
ROOTING	3-4 Mos	
DIGITAL RESPONSE	3-4 Mos	
PALMAR GRASP	3-4 Mos	
VERT. SUSPENSION	4 Mos	

Primitive Reflex	Vanish	Age/Date
TONIC NECK	6 Mos	
BLINKING	1 Year	
BABINSKI	2 Years	
ANTERIOR Fontanelle	4-26 Mos	
POSTERIOR Fontanelle	2-4 Mos	
SPHENOIDAL Fontanelle	15 Mos	
MASTOID Fontanelle	18 Mos	