General Information: Infant/Child Form

Date: _____

Child's Name: _____ Birthdate: _____

Parent(s) Name(s): _____

Address: _____ City: _____ State: _____

Zip Code: _____ E-mail: _____

Cell #: _____ Home #: _____ Work #: _____

Names and ages of siblings (if any): _____

How did you find us? Whom may we thank for referring your child? _____

Who is on your child's health care team? (Name of Obstetrician, Midwife, MD, other health care providers) _____

Health Profile

What is the reason your child is seeking services here? _____

Please list any other health concerns your child may be experiencing? _____

_____

What changes in your child's health or behavior would you like to see? _____

_____

Has your child had any surgery, hospitalizations, or diagnoses we should know about? _____

_____

Please briefly describe your child's food and fluid intake. Any vitamins/supplements? _____

_____

Please list any prescription or over-the-counter drugs your child is using or has used recently.

_____

Pregnancy and Labor of Your Child

Was labor induced? O Yes O No Duration of Labor? _____

Did mother receive drugs? O Yes O No _____

Type of birth? O Cephalic (head first) O Breech (feet first)

Location of Birth? O Home O Hospital O Birthing Center

Birth Assistants? O Midwife O Doula O Medical Doctor

Was there any assistance needed during birth? O Forceps O Cesarean O Vacuum Extraction

Were there complications during the pregnancy and/or birth? O Yes O NO

Please explain: _____

Was there any evidence of birth trauma to the infant?

O Bruising O Odd Shaped Head O Stuck in Birth Canal

O Very Long Birth O Respiratory Depression O Cord Around Neck

Did your child experience any of the following shortly after birth?

O Silver nitrate drops in eyes O Incubation

O Vitamin K shot O Hepatitis shot

Growth & Development

Any falls from couches, beds, change tables? O Yes O No _____

Any traumas resulting in bruises, fractures, stitches? O Yes O No _____

Did your child receive vaccinations? O Yes O No Any Reactions? _____

Was/Is the child breastfed? O Yes O No For how long? _____

Do you consider their sleep pattern normal? O Yes O No _____

Behavioral or Social Problems? O Yes O No _____

Is a school backpack used? O Yes O No (Heavy/Light)

Does your child consume:

O caffeine O soda O sugar

O artificial sweetener O fast food O processed foods

Has your child experienced any of the following?

O vision problems O pink eye O constipation

O headaches O ear problems O asthma

O sleeping difficulty O tubes in the ears O colic

O irritability O attention problems O allergies

O skin problems O frequent colds O bedwetting

O breathing problems O digestive problems O hyperactivity

O other _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any? _____

Any sports participation and age began? (list sports and number of hours/week): _____

_____

Signature of Parent: _____ Date: _____