INFANT PATIENT INTRODUCTION
NEWBORN to 5 MONTHS

Full Name: _____ Date: _____
FIRST MIDDLE LAST YYYY / MM / DD

Mailing Address _____
STREET CITY PROVINCE POSTAL CODE

Birthdate: _____ Age: _____ Height: _____ Weight: _____ ❑ Male ❑Female
YYYY / MM / DD LBS.

Alberta Health Care #: _____ ❑ My Child <u>does not</u> have AHC Coverage

Mother and/or Father's Name: _____ Home Phone #: _____

Mother and/or Father's Occupation: _____ Work Phone #: _____

Number and Ages of Siblings: Brothers: # _____ Ages: _____ Sisters: # _____ Ages: _____

We were referred by: ❑ FRIEND / RELATIVE ❑ DOCTOR ❑ PHONE BOOK ❑ SIGN

If you were referred by a doctor, friend or relative, please give their name: _____

Present MD? _____ Date of last MD Visit and reason: _____

Has your child previously seen a chiropractor? ❑ SINCE JULY 1 ❑ OVER A YEAR AGO ❑ NEVER

Who did your child see? _____

Describe your child's main health concern: _____

How long has your child had this condition? _____

❑ YES ❑ NO Has your child had these or similar conditions in the past? When? _____

What activities aggravate your child's condition? _____

Is this condition getting worse? ❑ YES ❑ NO ❑ Or is it CONSTANT

❑ YES ❑ NO Is this condition interfering with any of your child's daily activities? Check all that apply:
❑ PLAY ❑ SLEEP ❑ DAILY ROUTINES ❑ OTHER _____

❑ YES ❑ NO Any Hospitalizations? Explain: _____

❑ YES ❑ NO Vitamins/ Nutritional supplements? Type: _____

❑ YES ❑ NO Is your child currently taking any Medications?
Please list by name: _____

Please list any surgeries your child has had and the date(s): _____

Has your child ever been in an auto accident? ❑ NEVER ❑ PAST YEAR ❑ LAST 5 YEARS ❑ OVER 5 YEARS

Describe:

_____

_____

_____

_____

_____

HISTORY OF BIRTH:

During the pregnancy did the mother:

❑ YES ❑ NO Have any traumas (falls, accidents, etc.)? Explain: _____

❑ YES ❑ NO Take any drugs or vitamins? Please List: _____

❑ YES ❑ NO Have any illnesses? Please List: _____

❑ YES ❑ NO Have any invasive procedures (amniocentesis, CVs)? _____

❑ YES ❑ NO Have any exposures to Ultrasound? How many? _____ Medical Reason? _____

❑ YES ❑ NO Smoke? How often? _____ Alcohol?: _____

Was the baby born: ❑ In a HOSPITAL: _____ ❑ At HOME ❑ By a MIDWIFE:_____

❑ YES ❑ NO Was Labor Induced? Duration of gestation: _____

❑ YES ❑ NO Was it a Vaginal Birth: If *NO*: ❑ FORCEPS ❑ VACUUM EXTRACTION ❑ C-SECTION

Birth weight: _____ Birth Length: _____

❑ YES ❑ NO Were medications delivered to mother at birth: If *YES*, Please list: _____

Duration of Birth: _____

AFTER DELIVERY:

❑ YES ❑ NO Was there any difficulty with mother's lactation? Explain: _____

❑ YES ❑ NO Was there any evidence of birth trauma? Which? ❑ Bruising ❑ Odd shaped head

❑ Respiratory Depression ❑ Cord around Neck ❑ Other: _____

❑ YES ❑ NO Was this baby breast fed? How Long? _____ Formula introduced at what age? _____

Type of formula used? _____ Introduction of cow's milk at what age? _____

Began solid Foods at what age? _____ Type? _____

❑ YES ❑ NO Food/Juice Intolerance? Type: _____

❑ YES ❑ NO Any smokers in the home? How much? _____

❑ YES ❑ NO Any pets at home? Type: _____

❑ YES ❑ NO Any vaccinations? Which ones and any reactions? _____

❑ YES ❑ NO Any behavioral problems? Explain: _____

❑ YES ❑ NO Do sleeping patterns seem normal to you? Explain: _____

❑ YES ❑ NO Any falls from couches, beds, change tables, etc? _____

Average number of hours child watches TV per week: _____

At what age did the child: Crawl? _____ Walk? _____

❑ YES ❑ NO Any <u>MAJOR</u> health problems in the immediate family (Cancer, Disease, Diabetes, Etc.)?

Please List: _____

How many hours does your baby sleep between feeds? During the day? _____ At night? _____

YES	NO	
❑	❑	Does your baby have a preferred sleeping position? _____
❑	❑	Does your baby have any feeding difficulties? _____
❑	❑	Does your baby have a one sided breast-feeding preference? If *YES*, ❑ Right or ❑ Left
❑	❑	Does your baby frequently spit-up after feeding?_____
❑	❑	Does your baby cry a lot? For how many hours each day? _____
❑	❑	Does your baby pass a lot of intestinal gas? _____
❑	❑	Does your baby have any constipation or diarrhea? _____
❑	❑	Does your baby have a preferred head position? _____
❑	❑	Does your baby frequently arch his/her head or neck backwards? _____
❑	❑	Does your baby have any rashes or areas of dry skin? _____
❑	❑	Has your baby ever had a fever? _____
❑	❑	Has your baby ever had any falls? _____
❑	❑	Has your baby had any other trauma? _____
❑	❑	Do you have any other concerns you wish to discuss? _____

_____

_____