CHILD HISTORY FORM

Name: _____ Gender: □ Male □ Female **DOB: _____**

Present MD: _____ Present DC Name and Last Visit: _____

Main Concern: _____

_____

Other Care Received for This Issue Including Medication: _____

_____

Date of Onset: _____ Onset Was: □ Sudden □ Gradual □ Associated with an Event

Duration of Problem: _____ □ Minutes □ Hours □ Days □ Weeks □ Months □ Years

Pattern of Problem: □ Constant □ Intermittent □ Occasional □ Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

Effects of Problem on Bodily Function: _____

Prior Occurrences: _____

Other Health Concerns: _____

_____

HISTORY OF BIRTH

Hospital/Birthing Center: □ Home □ Medical □ Midwife **Weeks of Gestation: _____**

Birthing Assistance: □ Yes □ No **If Yes:** □Forceps □Vacuum □ C-Section □ Induced

Medications Used During Labor: □ Yes □ No **If Yes, What: _____**

Duration of Labor: _____ Duration of Birth: _____ Complications: □ Yes □ No

Explain Complications: _____ Delivery Normal: □ Yes □ No

APGAR at Birth: ___ After 5 Minutes: ____ Birth Weight: ____ Birth Length: ____

GROWTH AND DEVELOPMENT

Infant Responsive 12 Hours After Delivery: □ Yes □ No **Explain:_____**

What Age Did the Child Respond to: Sound____ Follow an object____ Vocalize____

Hold Head Up_____ Sit Alone_____ Teethe_____ Crawl_____ Walk_____

Normal Sleep Patterns: □ Yes □No **Chronic Disease: Mother's Side_____**

Father's Side_____ Siblings_____

CHEMICAL STRESSORS

Breast-Fed □ Yes □ No **How Long: _____ Formula Introduced at Age: _____**

Type of Formula: _____ Age Cow Milk Was Introduced: _____

Began Solid Food: _____ Type: _____ Age & Type of Baby Food: _____

Food/Juice Intolerance: □ Yes □ No **Type: _____**

During Pregnancy Did Mother: Smoke □ Yes □ No **Drink Alcohol** □ Yes □ No **Were There Any Smokers in the House:** □ Yes □ No **Did the Mother Experience Any Illness During Pregnancy** □ Yes □ No **Supplements used during pregnancy: _____ Drugs taken during pregnancy: _____ Exposure to Ultrasound** □ Yes □ No **How Many/Reason:_____ Invasive Procedures: _____ Number of Vaccinations: _____Reactions: _____ _____ Antibiotics:** □ Yes □ No **Number of courses: _____ Explain:**

_____

PSYCHOLOGICAL STRESSORS

Lactation Difficulties: □ Yes □ No **Problems Bonding:** □ Yes □ No **Behavioral Problems:** □ Yes □ No **Onset: _____ Sleep Problems:** □ Night Terrors □ Sleep Walking □ Other _____ **Age When Child Began Daycare: _____**

Does Your Child Seem Normal for Their Age: □ Yes □ No

TRAUMATIC STRESSORS

Traumas During Pregnancy: □ Falls □ Accidents □ Other _____

Evidence of Birth Trauma: □ Bruises □ Odd Shaped Head □ Head Stuck □ Fast or Excessively Long Birth □ Cord Around Neck □ Respiratory Depression □ Other _____

Has Baby Fallen From: □ Couch □ Bed □ Changing Table □ Other _____

Trauma: □ Bruising □ Cuts □ Stitches □ Fractures □ Other _____

Hospitalizations: □ Yes □ No **Explain: _____**

Any Surgeries/Organs Removed: □ Yes □ No **Explain: _____**

Any Other Questions/Concerns: _____

_____