Infant History

The following questions are designed to help the doctor provide the best possible spinal care for your child:

NUTRITION

	YES	NO	
Is your child still being breast fed?	☐	☐	If no, for how long was baby breast fed? _______ weeks/months
If still breast feeding, how much cow's/goat's milk does the mother consume each day?			________________________
Is your child formula fed?	☐	☐	Which formula or other milk source? ________________________
Is your child eating solid food?	☐	☐	What foods are in the diet? ________________________
			What is your child's favorite food? ________________________
Does your child have any feeding difficulties?	☐	☐	________________________
Does your child have any digestive issues?	☐	☐	________________________
Does your child have any food allergies?	☐	☐	________________________
Does your child have any persistent skin rashes?	☐	☐	________________________
Is your child taking any nutritional supplements?	☐	☐	________________________
Does your child pass a lot of intestinal gas?	☐	☐	________________________

TRAUMA

Has your child had any recent falls/trauma? ☐ ☐ ________________________

Describe the trauma and the date it occurred: ________________________

Has your child fallen down stairs/from any height? ☐ ☐ ________________________

Has child been in an auto accident or near miss? ☐ ☐ ________________________

Has your child ever had a fracture or dislocation? ☐ ☐ ________________________

Has your child banged their head repeatedly on a wall? ☐ ☐ ________________________

Has your child had any other trauma? ☐ ☐ ________________________

Has child ever had any negative reaction to a vaccine? ☐ ☐ ________________________

Infant History

GROWTH & DEVELOPMENT

	YES	NO	
Can your child sit unsupported?	☐	☐	At what age did your child start to sit up? ______________________
Is your child crawling yet?	☐	☐	At what age did your child start crawling? ______________________
Is your child walking yet?	☐	☐	At what age did your child start to walk? ______________________
Does your child often trip and fall?	☐	☐	____
Does you have other concerns about growth?	☐	☐	____ ____ ____

HEALTH HISTORY

Has your child had colic?	☐	☐	____
Has your child had any upper respiratory infections?	☐	☐	If yes, how often: ____
Has your child had asthma?	☐	☐	____
Does your child complain about neck/back pain?	☐	☐	____
Does your child ever complain about headaches?	☐	☐	____
Has your child had any ear aches/infections?	☐	☐	If yes, how often? ____ At what age was the first earache? ___________________________
Do the earaches tend to occur in the same ear?	☐	☐	If yes, which side? ____
Has your child had other illnesses?	☐	☐	____ ____
Is your child presently taking any medications?	☐	☐	____
Has your child been hospitalized?	☐	☐	____
Has your child been to the E.R for eval/treatment?	☐	☐	____
Has your child recently been vaccinated?	☐	☐	____
Which vaccines were recently administered?			____
Do you have any other concerns you wish to address	☐	☐	

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