

INFANT/CHILD HISTORY FORM

Date: _____
Patient's Full Name: _____ Birthdate: _____
Address: _____ City/State/Zip _____
Name of parent or guardian: _____ Phone: () _____
Height: _____ Weight: _____ Number of siblings: _____ Right or left handed: R L
Number of hours sleep per night: _____ Quality of sleep: Good Fair Poor
Name of pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Previous chiropractor? Yes No If yes, name: _____
Date of last visit: _____ Reason: _____

CHIEF COMPLAINT

Reason for visit today: _____
Other treatment for this symptom, including any medications given: _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I hereby authorize Copper Canyon Chiropractic, Dr. James Skabo, D.C. to administer care as they deem necessary to my child/ward.

Signed: _____ Date: _____

History of Complaint

Date of onset: _____ Sudden or gradual: _____
Duration of symptom: _____ Minutes Hours Days Weeks Months Year(s)
Pattern of pain or problem: Constant Intermittent Occasional
Cause of pain or problem if known: _____
What makes it better: _____
What makes it worse: _____
Effects of problem on body function and daily activities: _____

PRENATAL HISTORY

Duration of gestation: _____ weeks Pregnancy normal? _____
Any significant complications during pregnancy: _____
Was delivery normal? _____ Were drugs used during delivery? _____
Any complications during delivery: _____
Were forceps used? Yes No Place of delivery: Home Birthing Center Hospital
Apgar score at birth: _____ At five minutes: _____
Birth weight: _____ pounds _____ ounces Length: _____ inches

DEVELOPMENTAL HISTORY

Was the infant alert and responsive within 12 hours of delivery? Yes No
At what age did the child: respond to sound _____ hold head up _____ sit alone _____

NUTRITIONAL HISTORY

Breastfed? Yes No If yes, for how long? _____ months If no, formula type: _____
Cow's milk began at age: _____ Began solid food at age: _____

SOCIAL BEHAVIOR

Child seems normal for age? Yes No If no, explain: _____

CHILDHOOD DISEASES

Circle any that child has had: Chickenpox Mumps Measles Rubella Rubeola Whooping cough.
Has the child been immunized? Yes No If yes, any adverse reactions: _____
List any significant family history: cancer, diabetes, heart disease, ect: _____