

**Sheaffer Family Chiropractic**804 Loucks Rd., York PA
17404
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Infant Information

Child's Name _____ Date _____

Parent(s) Names _____

Siblings' Names and Ages _____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address _____

Would you like to receive our "Living Healthy" e-newsletter? Yes NoDate of Birth (MM/DD/YY) ____/____/____ Gender: Male Female

Home Ph _____ Business Ph _____ Mobile Ph _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

 Wellness Prevention Feel good Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:
_____Name & Address of Primary Health Care Provider:

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's health concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy _____

Any ultrasounds or other radiation? Yes No

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS)? Yes No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? Yes No How much? _____

Drink Alcohol? Yes No How much? _____

Prescription Medications? Yes No How much? _____

Recreational Drugs? Yes No How much? _____

Fall ill during pregnancy? Yes No please explain: _____

Were any supplements taken during the pregnancy? Yes No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high): _____

LABOUR

Was labor induced? Yes No

Duration of labor? _____ Duration of active (pushing stage) labor? _____

Did you receive any pain medication during labor? Yes No If yes, which: _____

BIRTH

Type of birth? Vaginal: Cephalic (head first) Breech (feet first) C-Section

Location of birth? Home Hospital Birthing center

Birth Assistants? Midwife Doula Obstetrician

Birth Continued...

Was there any assistance needed during birth?

Forceps Cesarean Vacuum Extraction Induction Assisted Traction/Head Turning

Was delivery considered normal? Yes No

Were there complications during birth? Yes No

Please explain: _____

Was there any evidence of birth trauma to the infant? Check all that apply:

- | | |
|--|--|
| <input type="radio"/> Bruising | <input type="radio"/> Odd shaped head |
| <input type="radio"/> Stuck in birth canal | <input type="radio"/> Fast or excessively long birth |
| <input type="radio"/> Respiratory depression | <input type="radio"/> Cord around neck |

Was your child subjected to any of the following? Check all that apply:

- | | | |
|--|---|-----------------|
| <input type="radio"/> Silver nitrate drops in eyes | <input type="radio"/> Incubation | How long? _____ |
| <input type="radio"/> Vitamin K shot | <input type="radio"/> Separation from you | How long? _____ |
| <input type="radio"/> Hepatitis shot | | |

Did your child spend any time in intensive care? Yes No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your baby have a preferred sleeping position? Yes No _____

Does your baby prefer one sided breast-feeding position? Yes No _____

Does your baby spit up after feeding? Yes No _____

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

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

Any hospitalizations or surgeries? Yes No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type _____ When _____ Hospitalized? Yes No
2. Type _____ When _____ Hospitalized? Yes No

Have you ever had x-rays taken? Yes No When? _____ Where? _____

What area of your child's body: _____

CHEMICAL STRESS

Was/is child breast-fed? Yes No For how long? _____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? Yes No _____

What vaccinations were given and at what age?

Reason for vaccinations _____

Were there any negative reactions? Yes No _____

Was there any:

- | | | |
|---------------------------------------|--|--|
| <input type="radio"/> Fever | <input type="radio"/> Un-consolable crying | <input type="radio"/> Irritability |
| <input type="radio"/> Arching of body | <input type="radio"/> Bowel disturbances | <input type="radio"/> Feeding disturbances |
| <input type="radio"/> Drowsiness | <input type="radio"/> Other: _____ | |

History of antibiotics? Yes No

If so, how many courses of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? Yes No _____

Are there any smokers at home? Yes No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

Night terrors, sleep walking, difficulty sleeping Yes No _____

Do you consider their sleeping pattern normal? Yes No _____

Quality of Sleep? Good Fair Poor Number of hours _____

Behavior problems? Yes No _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Does your child attend day care? Yes No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? Yes No

If no, please explain: _____

At what age did your child:

Respond to sound? _____

Sit alone? _____

Follow an object? _____

Teethe? _____

Hold head up? _____

Crawl? _____

Vocalize? _____

Walk? _____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

On father's side:

Does sibling's have any health concerns? Yes No

If yes, please describe: _____

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms of acceptance and
(CHILD'S NAME) hereby grant permission for my child to receive a chiropractic
assessment and chiropractic care.