



Breastfeeding Consultation Form (Child History)

Please take a few moments to complete this questionnaire for your child. If you need help with this form, please do not hesitate to ask. Thank you!

Personal Information

Child's Name _____ Gender M F Date _____

Mother/Guardian _____ Father/Guardian _____

Siblings names & ages _____

Date of Birth D _____ M _____ Y _____ Age _____

Address _____

City/Prov. _____ Postal Code _____

Best Phone# (_____) _____

E-Mail address _____

Referrals are our highest compliment, please share with us where you heard about our office:

- Current patient/a friend – name: _____
- Website Google search Social Media (FB/IG) Yellow Pages Online Yellowpages.com
- Beacon Phonebook Family Doctor _____ Midwife _____
- Other - please specify _____

Birth History

Birth weight: _____ Birth length: _____ Arrival time: _____ wks

Position at birth: Vertex (head down) Breech (bum down) Posterior (face-up) Transverse
Face first

Was labour: Spontaneous OR Induced → Membranes ruptured Cervical gel

Pitocin If induced, why? _____

Any Interventions used? Forceps Vacuum extraction Manual pulling by doctor

Epidural None

Type of Birth: Vaginal C-Section Duration of labour: _____

Location: Home Hospital Assisted by: Midwife Doctor

Apgar scores (if known): _____

Any complications during/after delivery? None Bruising of face/head Respiratory distress Difficulty breastfeeding Other _____

Any problems during pregnancy with this child? Fall onto buttocks Low back pain
 Gestational diabetes Hypertension Car accident Other _____

Has this child ever been to a Chiropractor? No Yes
Name of previous Chiropractor & city _____
Approximate date of last visit: _____

Has this child ever had any x-rays taken? No Yes Of what area(s)? _____
Has this child ever been hospitalized or had any surgical operations? No Yes _____
Has this child ever had ear infections? No Yes How many and when? _____
Has this child ever been prescribed antibiotics? No Yes Approximate dates and reasons: _____
Has this child ever been prescribed any other medications? No Yes _____
Does this child currently take any medications? No Yes _____
Does this child currently take any natural supplements No Multivitamins Omega 3 Other _____

Please rate the quality of this child's sleep: Poor Fair Good Excellent
Number of sleeping hours at night: _____ Number of napping hours during the day: _____

Has this child been exposed to second hand smoke? No Yes _____

Does mother currently take any medications? No Yes _____
Is mother a smoker? No Yes Is father a smoker? No Yes

Consent to Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have you (the mother) and your child examined by Dr. Tanya Chambers at the Stratford Chiropractic & Wellness Centre. The purpose of this examination is to assist with difficulty breastfeeding. The examination may include but not be limited to manual hands-on palpation (touching) of the child's body (face, jaw, mouth, and spine) and the mothers body (specifically breasts). The exam may also include a chiropractic examination, which is a "hands-on" approach so that we can best assess your child's health.

Child Name

Parent/Guardian Name

Parent/Guardian Signature

Date

Doctor Witness Signature

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur