STRATFORD
Chiropractic
&Wellness
CENTRE

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Pip Penrose | Dr. Blair Neely
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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 Nancy, Nicole, Carrie or Erin. 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 _____
Home Phone (_____)_____ E-Mail address _____
Parent's Business/Employer_____Business Phone(_____)_____
May we call you at work? ☐ No ☐ Yes Best time to reach you:_____

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

☐ Current patient – who?_____ ☐ Yellow Pages ☐ Beacon Phonebook
☐ Stratford Midwives
☐ 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

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