Dr. Pam Manning, D.C.

253 Church Street
Markham, Ont.
L3P 2M6

INFANT HISTORY

Name _____ Date _____
Address _____
Date of Birth_____ Health # _____Version letter _____
Phone of Parent/Guardian (Home) _____ (Bus.) _____
Height _____ Weight _____
Referred By _____
Name of M.D./Pediatrician _____
Date of last M.D. visit _____ Reason _____
Previous Chiropractor_____
Date of last chiropractic visit _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize _____ to administer care as they deem necessary to my son/daughter.

Signed _____ Witnessed _____
Date_____ Date _____

CHIEF COMPLAINT

Reason for contacting us _____
List all therapies undergone for this complaint (Incl. Medication) _____
_____
Date of onset _____ Onset was sudden
gradual
Duration of symptoms _____
Pattern of symptoms Constant Intermittent Occasional
Initiating factors _____
Aggravating Factors _____
Relieving Factors _____
Effects of symptoms on daily activities _____
Gestation _____ weeks
List any complications during pregnancy _____
_____
Was delivery normal Yes No
List any medications taken during pregnancy _____

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List any medication taken during delivery

_____

Forceps used during delivery Yes No _____

Place of Birth _____

Apgar score at birth _____ Weight at birth _____

Apgar score at 5 mins. _____ Length at birth _____

DEVELOPMENTAL HISTORY

Was the infant alert and responsive within 12 hours of delivery? Yes No

If No, explain_____

At what age did the child;

Respond to sound _____

Follow objects with his/her eyes _____

Hold head up _____

Sit alone _____

Crawl _____

Stand _____

Vocalize _____

Teethe _____

Sleep hours _____

Walk alone _____

NUTRITIONAL HISTORY

Breastfed _____ months

Formula began at age _____ for _____ months

Type of Formula used _____

Cow's milk began at age _____ Other milk

Solid food began at age _____

Were commercially prepared baby foods used? Yes No Type _____

Food/Juice intolerence Yes/No Type _____

SOCIAL BEHAVIOUR

Seems normal for age Yes / No

If No, please explain _____

_____

_____

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CHILDHOOD DISEASES

Please circle applicable diseases and indicate age contracted.

Chicken Pox _____
Mumps _____
Measles
    Rubella (German Measles) _____
    Rubeola _____
Whooping Cough _____
Other _____

Immunization - List type and age
_____
_____

Reaction to Immunization Yes No
If Yes, explain _____

List any significant family history (cancer, diabetes, heart disease ect.)
_____
_____

Include hospitalizations, medications, trauma etc. _____
_____