INFANT HEALTH HISTORY FROM 0-2 YEARS Date: ___________________________

At Parascak Family Chiropractic we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you into this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Daily, we experience physical, emotional, and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced throughout his/her lifetime, allowing us to better assess the challenges to his/her health potential.

Child's Name: ____

Address: ___________________________ City: ________________ Prov: __________

Postal Code:______________ Date of Birth (M/D/Y): ______________Age: _______________

Sex: □ M □ F Height: ______________ Weight: ______________

Extended Health Care: □ No □ Yes Alberta Health Care #: ______________________

Mom's Name: ______________________________ Mom's Phone #: ____________________

Dad's Name: ______________________________ Dad's Phone #: ____________________

Mom's/Dad's Email (for in office use only):______________________,______________________

Previous Chiropractor: ______________________________Last Visit: ________________

Referred to this office by: ____

PURPOSE OF THIS VISIT TO OUR OFFICE

□ Spinal screening □ Wellness care □ Accident/Fall □ Illness □ Other Health Problem: ________________

1. Have any other Doctors been consulted for this condition? □ No □ Yes, please provide the Doctor's name(s) and types of treatments: ____
2. Other health problems you would like to discuss: __________________________________

   ____
3. Check any of the following conditions your child has suffered from during their lifetime:

□ Asthma/Allergies	□ Scoliosis	□ Recurring Fevers	□ Sleeping troubles	□ Back/Neck or "Growing" Pains
□ Ear infections	□ Diabetes	□ Headaches	□ Car Accident	□ Numbness or Tingling
□ Poor Appetite	□ Diarrhea	□ Seizures	□ Dizziness	□ Digestive Problems
□ Hyperactivity	□ Colic	□ Constipation	□ Stomach Aches	□ Learning Disabilities
□ Bed wetting	□ Fatigue	□ Chronic Colds	□ Temper Tantrums	□ Other: ______________

   ____
4. Family Health History: ____
5. Name of Family Physician: ______________________Clinic: ______________________

   Date of Last Visit: ________________Purpose: ______________________________
6. Number of doses of *antibiotics* your child has taken:

   During the past six months: ______________Total during his/her lifetime: ________________
7. Number of doses of *other prescription medications* your child has taken:

   During the past six months: ______________Total during his/her lifetime: ________________
8. Please list the medications: ____

   ____
9. Has your child been vaccinated? □ No □ Yes, please list: ______________________________

CHILDHOOD DISEASES

Has your child had any of the following illnesses? (please indicate age if applicable)

□ Measles (Rubella) ______________ □ Mumps __________ □ Rubella (German Measles) ________________

□ Pertussis (Whooping cough) ___________ □ Chicken pox ___________ □ Other _________________________

PRENATAL HISTORY

1. Name of Obstetrician/Doctor:____
2. Ultrasounds During pregnancy?_ □ No □ Yes, how many? _______________________________________
3. Was there any smoking during pregnancy? □ No □ Yes, how much? _______________________________
4. Medications during pregnancy? □ No □ Yes, please List: ____
5. Complications during pregnancy? □ No □ Yes, please List: ____
6. Location of birth: □ Hospital □ Birthing Centre □ Home
7. Was an epidural given? □ No □ Yes
8. Type of birth: □ Vaginal □ Forceps □ Vacuum Extraction □ Breech □ Caesarean, □ Planned □ Emergency
9. Complications during labour/delivery? □ No □ Yes, Please List: ___________________________________
10. Birth weight: _______________ Birth length: _______________ APGAR scores: __________, __________
11. Genetic disorders or disabilities? □ No □ Yes, Please List: _______________________________________

FEEDING HISTORY:

1. Breast fed? □ No □ Yes, How long? ____
2. Formula Fed? □ No □ Yes, How long? ____
3. Food allergies or intolerances? □ No □ Yes, Please list: ____
4. Introduced solid foods at _________ months. Introduced cow's milk at __________ months.
5. Does your child consume any foods containing: □ Caffeine □ Artificial sweeteners (ex: aspartame/nutrasweet)

DEVELOPEMENTAL HISTORY:

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of spinal nerve interference. (vertebral subluxation)

1. At what age was your child able to:
   Respond to sound __________. Follow an object with their eyes __________. Hold head up __________.
   Sit up ____________. Crawl ____________. Stand alone ____________. Walk alone ____________.
2. According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of their life (ex: bed, change table, down stairs, from shopping carts, etc.). Has your child experienced any of these traumas? Describe: ____
   ____
3. Has your child ever been treated on an emergency basis? □ No □ Yes, describe: _____________________
   ____
4. Any other injuries or falls that have not been described above? □ No □ Yes, describe: __________________
   ____
5. Surgeries/Operations? □ No □ Yes, describe: ____
   ____