Pittsburg Chiropractic Center…Your Wellness Connection

Infant History

2 months to 2 years

Today's Date ___________________

Patient's Name ________________________ Sex: M F Date of birth ________________ Age ________

The following questions are designed to help the doctor provide a detailed evaluation of your child.

Nutrition

Yes No

☐ ☐ Is your child still being breast fed? If no, how long was he/she breast fed ____________
If still breast-feeding, how much cow's milk does the mother consume each day? ______

☐ ☐ Is your child formula fed? Which formula or other milk source? ___________________

☐ ☐ Is your child eating solid food? What foods does his/her diet contain? _______________
__________________ What is your child's favorite food? ________________________

☐ ☐ Does your child have any feeding difficulties? __________________________________

☐ ☐ Does your child have any digestive disturbances? _______________________________

☐ ☐ Does your child have any food allergies? ______________________________________

☐ ☐ Does your child have any persistent or intermittent skin rashes? ____________________

☐ ☐ Is your child receiving any vitamin supplements? _______________________________

Trauma

Yes No

☐ ☐ Has your child had any recent falls or trauma? Describe the trauma and the date it
Occurred?____

☐ ☐ Has your child ever fallen down stairs or fallen from any height? ___________________

☐ ☐ Has your child ever been in a motor vehicle accident or near-miss? __________________

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _______________________

☐ ☐ Has your child had any other trauma or injuries? _________________________________

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed, or other object?
____

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Growth and Development

Yes	No	
☐	☐	Can your child sit unsupported? At what age did your child start to sit-up? ______ mths
☐	☐	Is your child crawling yet? At what age did your child start crawling? _________ mths
☐	☐	Is your child walking yet? At what age did your child start to walk? ___________ mths
☐	☐	Does your child often trip and fall? ____
		Does you have any other concerns about your child's growth and development? _______

Health History

Yes	No	
☐	☐	Has your child had colic?____
☐	☐	Has your child had any upper respiratory infections? How often? ___________________
☐	☐	Has your child had asthma? ____
☐	☐	Does your child ever complain of pains in the arms or legs? _______________________
☐	☐	Does your child ever complain of headaches? ___________________________________
☐	☐	Does your child ever complain of back or neck pain? ____________________________
☐	☐	Has your child had any earaches? At what age did the first earache occur ____________
☐	☐	How frequently does your child have earaches? _________________________________
☐	☐	Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? __
☐	☐	Has your child had any other illnesses? Pleas list each illness and its approximate date ____
☐	☐	Is your child presently receiving any medications? ______________________________
☐	☐	Has your child ever been to a hospital or emergency room for evaluation or treatment? ____
☐	☐	Has your child recently been vaccinated? ______________________________________
☐	☐	Do you have any other concerns about your child's health? ________________________