

**Patient Information**

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Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

**Mother's History**

**Tell me about your prenatal time:**

a. Did you exercise?  **Y**  **N** Please explain: \_\_\_\_\_

b. Did you drink alcohol?  **Y**  **N** Please explain: \_\_\_\_\_

c. Did you take drugs?  **Y**  **N** Please explain: \_\_\_\_\_

d. Did you eat regularly?  **Y**  **N** Please explain: \_\_\_\_\_

e. Did you have any spinal pain or problems during your pregnancy?  
 **Y**  **N** Please explain: \_\_\_\_\_

**Labor:**

a. How long was your labor? \_\_\_\_\_

b. Was labor artificially induced?  **Y**  **N**

c. Would you say it was:  Easy  Hard  Very Hard

d. Did you have a spinal block?  **Y**  **N**

e. How did you deliver the child?  
 On back  On all fours  Squatting  Sitting up in a birthing chair  Other \_\_\_\_\_

f. Did the doctor grasp/pull on child's head?  **Y**  **N**  
Did you notice if the doctor twisted?  **Y**  **N**  
Were forceps used?  **Y**  **N**

g. Do you remember the APGAR score?  **Y**  **N**  
If so, what was it? \_\_\_\_\_

h. Any complications? \_\_\_\_\_

## Baby's History

Was this child breastfed?  **Y**  **N** How long? \_\_\_\_\_

Did this child have any unusual or strange habits or behaviours as a newborn? \_\_\_\_\_

a. Colic?  **Y**  **N**

b. Fussy?  **Y**  **N** c. Alert?  **Y**  **N** d. Happy?  **Y**  **N**

e. Did child have shots (immunizations)?  **Y**  **N**

f. Did child crawl?  **Y**  **N** Beginning at what age? \_\_\_\_\_ months

g. Was child in a walker?  **Y**  **N** How long? \_\_\_\_\_

h. For how long did the child crawl? \_\_\_\_\_

i. At what age did child begin to walk? \_\_\_\_\_

j. Did you notice anything unusual about the child's efforts to learn to walk?  **Y**  **N**

Did the child fall a lot?  **Y**  **N**

Were there any particularly hard falls that you recall?  **Y**  **N**

If so, please explain: \_\_\_\_\_

## Young Child

a. Ear infections?  **Y**  **N**

b. Colds?  **Y**  **N**

c. Mucus/Sinus trouble?  **Y**  **N**

d. Falls?  **Y**  **N**

e. Collisions (Automobile)?  **Y**  **N**

Anything else you have noticed about your child that you think is unusual: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List any medications, past or present: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any diagnosed diseases: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Mother, Father, or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_