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Infant Information

NOBLE CHIROPRACTIC PC

Date _____

For Office Use Only: ID #: _____

Child's Name _____

Parent(s) Names _____

Siblings' Names and Ages _____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address _____

Would you like to receive our "Living Healthy" e-newsletter? Yes No

Date of Birth ____m/____d/____y/ Gender: Male Female

Home Ph _____ Business Ph _____ Mobile Ph _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

Wellness Prevention Feel good Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife: _____

Name & Address of Primary Health Care Provider: _____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's health concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy _____

Any ultrasounds or other radiation? Yes No

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS) ? Yes No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? Yes No How much? _____

Drink Alcohol? Yes No How much? _____

Prescription Medications? Yes No How much? _____

Recreational Drugs? Yes No How much? _____

Fall ill during pregnancy? Yes No please explain _____

Were any supplements taken during the pregnancy? Yes No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high): _____

LABOUR

Was labour induced? Yes No

Duration of labour? _____

Duration of active (pushing stage) labour? _____

Did you receive any pain medication during labour ? Yes No

If yes, which: _____

BIRTH

Type of birth? Vaginal: Cephalic (head first) Breech (feet first) C-Section

Location of birth? Home Hospital Birthing center

Birth Assistants? Midwife Doula Obstetrician

Was there any assistance needed during birth?

Forceps Cesarean Vacuum Extraction Induction Assisted Traction/Head Turning

Was delivery considered normal? Yes No

Were there complications during birth? Yes No

Please explain:

Was there any evidence of birth trauma to the infant? Check all that apply:

Bruising

Odd shaped head

Stuck in birth canal

Fast or excessively long birth

Respiratory depression

Cord around neck

Was your child subjected to any of the following? Check all that apply:

Silver nitrate drops in eyes

Incubation

How long? _____

Vitamin K shot

Separation from you

How long? _____

Hepatitis shot

Did your child spend any time in intensive care?

Yes No If yes, how long? _____

APGAR score at birth? _____

APGAR score at 5 minutes? _____

Birth Weight? _____

Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your baby have a preferred sleeping position? Yes No _____

Does your baby prefer one sided breast-feeding position? Yes No _____

Does your baby spit up after feeding? Yes No _____

Any falls from couches, beds, change tables? Yes No _____

Any traumas resulting in bruises, fractures, stitches? Yes No _____

Any hospitalizations or surgeries? Yes No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type _____ When _____ Hospitalized? Yes No

2. Type _____ When _____ Hospitalized? Yes No

3. Type _____ When _____ Hospitalized? Yes No

Have you ever had x-rays taken? Yes No When? _____ Where? _____

What area of your child's body: _____

CHEMICAL STRESS

Was/is child breast-fed? Yes No For how long? _____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? Yes No _____

What vaccinations were given and at what age?

Reason for vaccinations _____

Were there any negative reactions? Yes No _____

Was there any:

Fever

Un-consolable crying

Irritability

Arching of body

Bowel disturbances

Feeding disturbances

Drowsiness

Other: _____

History of antibiotics? Yes No

If so, how many courses of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? Yes No _____

Are there any smokers at home? Yes No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

Night terrors, sleep walking, difficulty sleeping Yes No _____

Do you consider their sleeping pattern normal? Yes No _____

Quality of Sleep? Good Fair Poor Number of hours _____

Behavior problems? Yes No _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Does your child attend day care? Yes No From what age? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? Yes No

If no, please explain: _____

At what age did your child:

Respond to sound? _____

Sit alone? _____

Follow an object? _____

Teethe? _____

Hold head up? _____

Crawl? _____

Vocalize? _____

Walk? _____

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

On father's side:

Does sibling's have any health concerns? Yes No

If yes, please describe: _____

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. YOUR NAME or other attending chiropractor.

(SIGNATURE)

(DATE)

(WITNESS)

Consent to assess and adjust a minor:

I, _____, being the parent or legal guardian of

(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms

(CHILD'S NAME)

of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.