Initial Infant and Child Questionnaire

Name: _____
Birthday: _____
Mommy's name: _____
Daddy's name: _____
Purpose for visit: _____

Pregnancy

Did you carry to full term? _____ If not, how many weeks? _____
Any complications? _____
When did they occur? _____
Did you consume alcohol during the pregnancy?_____ Amount: _____
Did you smoke? _____ How much? _____ How long? _____
Any medications during your pregnancy? _____
Did you have exposure to ultrasound? _____ How many? _____

Labor & Delivery

Did you use a midwife? _____ ObGyn? _____ Hospital? _____
Did you have an epidural? _____Were you induced? _____
Forceps? _____ Vacuum extraction? _____ C-Section? _____
Was it a difficult birth? _____ Hours in labor? _____
What was the baby's APGAR Score at birth? _____ At 5min? _____

Birth to 2 years-Any of the following occur:

__ Fall from changing table
__ Tumble down stairs
__ Fall our of crib
__ Involved in car accident
__ Playground injury
__ Frequent ear infections
__ Colic
__ Frequent Diarrhea
__ Constipation
__ Sleeping problems
__ Frequent colds
__ Not gain weight
__ Frequent fevers
__ Other

Please explain the above: _____
_____

Three-Five years old– Any of the following occur:

__ Fall from tree
__ Fall off bicycle
__ Playground injury
__ Sports injury
__ Car accident
__ Stomach aches
__ Scoliosis
__ Bed wetting
__ Hyperactive
__ Autism
__ Learning disabilities
__ Asthma/Allergies
__ Leg/Knee pain
__ Other

Please explain the above: _____

_____

Vaccinations

Is your child up to date on their vaccines? _____
Has your child ever had a reaction to a vaccine? _____
Were you told of pros/cons of vaccines? _____
Did you know you have a choice in vaccinating your child? _____
Would you like information on the other side of the issue? _____

Miscellaneous

Describe any hospital stays: _____

_____

How many times has your child been on antibiotics and for what Condition? _____
List all medications your child is currently taking: _____

_____

Is there anything else you feel we should know? _____

_____

(Initial)_____**Consent to Care for Minor Child:** I hereby authorize Dr. Purdy and whomever he may designate as his assistants to administer Chiropractic care as he deems necessary to my relative.

Signature of parent/guardian: _____
Date: _____