Vital Information (Child)

First Name:_____ Last Name:_____

Parent(s) Names: _____

Siblings Names and Ages: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Parents email address: _____

Home Phone: (____) _____Business Phone: (_____) _____

Date of Birth: /M_____ /D_____/Y_____

Reason for seeking services at the Café of Life?_____

_____

Who may we thank for referring you to the Café of Life?

_____

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

_____

_____

PREGNANCY:

Trauma/ illness during pregnancy: _____

During pregnancy did mother Smoke? Yes No How much? _____

Drink? Yes No How much? _____

Any supplements taken during pregnancy? Yes No _____

Any drugs taken during pregnancy? Yes No _____

Any ultra sounds or other radiation? Yes No How many and for what reasons?

_____

Any invasive procedures during pregnancy (ie. amniocentesis, CVS etc.)? Yes No

Please explain _____

LABOUR:

Position during labour? On back? Yes No

On Side, Sitting, Standing? Yes No

Was labour induced? Yes No

Did you receive drugs? Epidural? Yes No

Morphine? Yes No

Other _____ Yes No

Did mother have episiotomy? Yes No

Was monitoring used? Internal monitor? Yes No

External monitor? Yes No

Duration of labour: _____

BIRTH

Type of birth? Cephalic (head first) ☐ Breech (feet first) ☐

Location of birth? Home ☐ Birthing center ☐ Hospital ☐

Birth Assistants? Midwife ☐ Doula ☐ Medical Doctor ☐

Any assistance needed during birth? Forceps ☐ Vacuum extraction ☐ Cesarean ☐

Any complications during birth? Yes ☐ No ☐ Please explain: _____

_____

Was the Child delivered before, on, or after the due date (how long)? _____

Birth weight _____ Birth length _____

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

Was infant alert and responsive within 12 hours of delivery? Yes No
If no, explain: _____

Congenital anomalies/ defects present? _____

VACCINATION HISTORY:

What vaccinations and age given?_____

_____

Any negative reactions? Yes No _____

Reason for vaccinations? _____

GROWTH AND DEVELOPMENT:

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

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

Any hospitalizations or surgeries? Yes No _____

History of antibiotics? Yes No _____

Do you consider sleeping pattern normal? Yes No _____

Number of hours of sleep? _____ Quality? Good ☐ Fair ☐ Poor ☐

Night terrors, sleep walking, difficulty sleeping? Yes No _____

Was child breast fed? Yes No How long? _____

Difficulties with lactation Yes No _____

Formula introduced at what age? _____ What Formula? _____

Introduction of cows milk at what age?

_____

Solid foods at what age?_____ Type of food? _____

Food/juice intolerance?_____

Problems with bonding? *Yes* *No* _____

Behavior problems? *Yes* *No* _____

Age of child when began daycare? _____

Do you feel that your child's social and emotional development is normal for their age?

Cont.

Yes *No* _____

Any sports played? *Yes* *No* _____

Is school backpack used? *Yes* *No* *Heavy* ☐ *Light* ☐

AUTHORIZATION FOR CARE OF A MINOR (Under Age 16)

Print Parent Name

_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

*Parent/Guardian Signature*_____ *Date* _____

Witnessed Signature _____

Name of Obstetrician / Midwife: _____

Name of Pediatrician/ Family MD: _____

Date of last visit to MD: _____ *Purpose of visit:* _____