Healing Horizons

Integrated Health Solutions

Infant Health History

(Ages 0-1)

Name: _____ DOB: _____ Date: _____

Parent(s)/Guardian(s) Name(s): _____ Enrolled in Medicare? ☐ Yes ☐ No

Chief Complaint: _____

How and when did it start? _____

What makes it better? _____ What makes it worse? _____

Has your child been treated for this condition before? ☐ Yes ☐ No If yes, by whom? _____

Is your child currently under a healthcare provider's care for any other problems? ☐ Yes ☐ No

Previous Chiropractic Care: Last visit? Reason? Duration of care? _____

_____

Current Medications/Antibiotics/Supplements: _____

_____

Past Medications/Antibiotics: _____

_____

Hospital/ER Visits/Surgeries? _____

_____

Other Injuries/Accidents: _____

_____

Prenatal History

Complications During Pregnancy: (circle, if any)

Toxemia Diabetes Morning Sickness Heartburn Back Pain Headaches Other

Mother's Health/Nutrition: (circle one) Poor Good Excellent

Stress During Pregnancy: (rate 1-10) ____ Falls/Injuries/Accidents During Pregnancy: _____

Family History of: (circle, if any) Diabetes Heart/Cardio Problems Other_____

Complications During Delivery: (circle)

None C-Section Vacuum/Forceps Induced Epidural Fetal Distress Meconium Oxygen ICU

Birth Injuries: (list) _____

Birth Weight: _____ Birth Length: _____ APGAR: _____,_____

Feeding History:

Breastfed: (circle one) N Y - How Long? _____ Difficulties? N Y - _____

Baby Prefer One Side: N Y - Which? _____ Formula? N Y - _____

Introduced Solids: N Y - What? _____ When? _____

Food Allergies/Intolerances: N Y - List _____

Developmental History:

At what age was your child able to: Hold Head Up___ Roll Over___ Sit Up___ Crawl___ Stand___ Walk___

Vaccines: (circle)

Y N Partial Complete

Reactions, if any: (fever, fussy, etc.)

Slight Mild Severe

Describe reactions: _____

Check any of the following that your infant has suffered from:

- ☐ Asthma
- ☐ Digestive Difficulties
- ☐ Ear Infections
- ☐ Feeding Difficulties
- ☐ Head Banging
- ☐ Heart Conditions
- ☐ Inconsolable Crying/Colic
- ☐ Recurrent Fevers
- ☐ Seizures
- ☐ Spitting Up/Vomiting
- ☐ Weight Loss/Poor Weight Gain

Patient Name: _____ Signature: _____ Date: ___/___/___

Parent or Guardian: _____Signature: _____ Date: ___/___/__