

General Information: Infant/Child Form



Child's Name _____

Birth Date ___/___/___

Parent(s) Name(s) _____

Today's Date ___/___/___

Address _____ City _____

State _____ Zip Code _____ E-Mail _____

Home # _____ Work # _____ Cellular # _____

Please indicate the best phone number to contact you: Home ___ Work ___ Cellular ___

Age of child _____ Names and ages of siblings (if any) _____

How did you find us? Whom may we thank for referring your child? _____

Who is on your child's health care team? (Name of Obstetrician, Midwife, MD, other health care providers)

Health Profile

What is the reason your child is seeking services here? _____

Please list any other health concerns your child may be experiencing? _____

What changes in your child's health or behavior would you like to see? _____

Has your child had any surgery, hospitalizations, or diagnoses we should know about?

Please briefly describe your child's food and fluid intake. Any vitamins/supplements? _____

Please list any prescription or over-the-counter drugs your child is using or has used recently. _____

Pregnancy and Labor of Your Child

Was labor induced? Yes No Duration of labor? _____

Did mother receive drugs? Yes No _____

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

Location of birth? Home Hospital Birthing center

Birth Assistants? Midwife Doula Medical Doctor

Was there any assistance needed during birth?

Forceps Cesarean Vacuum extraction

Were there complications during the pregnancy and/or birth? Yes No Please explain:

Was there any evidence of birth trauma to the infant?

Bruising Odd shaped head Stuck in birth canal
 Very long birth Respiratory depression Cord around neck

Did your child experience any of the following shortly after birth?

Silver nitrate drops in eyes Incubation
 Vitamin K shot Hepatitis shot

Growth and Development

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

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

Did your child receive vaccinations? Any poor response? Yes No _____

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

Do you consider their sleeping pattern normal? Yes No _____

Behavioral or social problems? Yes No _____

Is school backpack used? Yes No (Heavy / Light)

Does your child consume:

caffeine

soda

sugar

artificial sweetener

fast food

processed foods

Has your child experienced any of the following?

vision problems

pink eye

constipation

headaches

ear problems

asthma

sleeping difficulty

tubes in the ears

colic

irritability

attention problems

allergies _____

skin problems

frequent colds

bedwetting

breathing problems

digestive problems

hyperactivity

other _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any?

Any sports participation and age began? (list sports and number of hours/week) _____

Signature of Parent _____

Date ____/____/____