HISTORY OF BIRTH

Hospital / birthing center: ❑ home ❑ medical ❑ midwife Duration of Gestation: _________weeks

Assisted With: ❑ No ❑ Yes. If yes: ❑ forceps, ❑ vacuum extraction, ❑ c-section, ❑ induced labour.

/edications delivered to mother at birth? ❑ No ❑ Yes. If yes what? ______________________Duration of birth: ________________

Complications at birth: ❑ No ❑ Yes Explain____ Was delivery normal? ❑ Yes ❑ No

APGAR at BIRTH______________ AFTER 5 MINUTES __________BIRTH WEIGHT _______________BIRTH LENGTH_____________

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? ❑ Yes ❑ No Explain______________________________

At what age did the child: Respond to sound __________ Follow an object__________ Hold up head_________ Vocalize ________

Sit alone ______Teethe_________________ Crawl ________________ Walk __________________Do sleeping patterns seems normal

to you: ❑ Yes ❑ No. Any health problems (cancer, diabetes, heart disease, etc.) on the mother' side of the family________ On the father's _____

With siblings ________________ Since problems that chiropractors concern themselves with can be related to many types of stressors, the following

information is also very important to us!

CHEMICAL STRESSORS:

Was this baby breast-fed? ❑ No ❑ Yes How long ________________________Formula introduced at age ________ Type of formula used

________________Introduction of cow's milk at age _______________Began solid foods at age_________ Type_________ Age & type of

commercial baby food introduction_______________________ Food /Juice intolerance ❑ No ❑ Yes Type:____________________

During pregnancy did the mother smoke? ❑ Yes ❑ No Did the mother drink alcohol? ❑ Yes ❑ No. Any illness of the mother during

pregnancy? ____ Any supplements of mother during pregnancy:________________

Any drugs taken during pregnancy ____Any exposures to ultrasound: ❑ No ❑ Yes If so, how

ıany and what was the medical reason? ____________________________________Any invasive procedures (amniocentesis, CVS): ______

Any pets at home? ❑ No ❑ Yes Any smokers in the home? ❑ No ❑ Yes (How much) ________________Any vaccinations? Which ones

and any reactions? _____________________________Any antibiotics? ❑ No ❑ Yes Explain:_______________________________

Total number of courses of antibiotics to date: ____

PSYCHOSOCIAL STRESSORS.

Any difficulties with lactation?: ❑ No ❑ Yes Any problems with bonding? ❑ No ❑ Yes Any behavioural problems? ❑ No ❑ Yes

Onset: _____________Any night terrors, sleepwalking, difficulty sleeping? ❑ No ❑ Yes Specify________________Age of child when

began daycare? _____ Average number of hours of television/week? ______ Does your child seem normal for their age? ❑ Yes ❑ No

TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents)_______________________________________Any evidence of birth trauma: bruises, odd

shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other__________________________

Any falls from couches beds, change tables ____________________Any traumas with bruising, cuts, stitches fractures__________________

Any hospitalizations: ❑ No ❑ Yes Explain____

Any surgeries or organs removed ____Sports played and age began ____________

____Number of hours per week played_______________________________

Weight of school backpack____Approx. hours spent at play per week_______

Thank you for completing this form. Please write any other questions you have below.______________________________________