INFANT-TODDLER HEALTH RECORD

ABOUT THE CHILD

PATIENT NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

ABOUT THE PARENTS

PARENTS/LEGAL GUARDIANS NAMES:	
ARE YOU THE PARENT OR LEGAL GUARDIAN: ❑ PARENT ❑ GUARDIAN	
MARITIAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECASE OF (ALL THAT APPLY): ❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR? ❑ YES ❑ NO

MEDICATIONS/VACCINATIONS

NUMBER OF DOSES OF PRESCRIPTION MEDICATION CHILD HAS TAKEN DURING HIS/HER LIFETIME:
PLEASE LIST ALL MEDICATIONS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: ❑ DPT ❑ MMR ❑ CHICKEN POX ❑ HEPATITIS ❑ OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE (S):

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ WELLNESS ❑ CONDITION
IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: ❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE
DOES THIS CONDITION INTERFERE WITH: ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS/CHIROPRACTOR FOR THIS CONDITION? ❑ YES ❑ NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS:

Vitalize Chiropractic: A Creating Wellness Center
4980 Benchmark Centre, Suite 100
Swansea, IL 62226

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:

❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL

IF YES, PLEASE LIST:

LOCATION OF BIRTH:

❑ HOME ❑ BIRTHING CENTER ❑ HOSPITAL

DESCRIBE YOUR DELIVERY:

❑ LABOR WAS CHEMICALLY INDUCED ❑ LABOR WAS DOCTOR ASSISTED
❑ C-SECTION DELIVERY ❑ FORCEPTS/VACUUM EXTRACTION
❑ DOCTOR PULLED OR TWISTED BABY ❑ PREMATURE DELIVERY

PLEASE EXPLAIN:

DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?

❑ YES ❑ NO

PLEASE EXPLAIN:

PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

BIRTH WEIGHT:

BIRTH LENGTH:

APGAR SCORES:

ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO NUMBER: _____

DID YOU BREASTFEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

DID YOU FORUMULA FEED THE BABY? ❑ YES ❑ NO

IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?

❑ YES ❑ NO

LIFESTYLE HABITS

DOES YOUR CHILD EXERCISE DAILY? ❑ YES ❑ NO
HOW MUCH?

DOES YOUR CHILD DRINK SODA? ❑ YES ❑ NO
HOW MUCH?

DOES YOUR CHILD TAKE VITAMINS? ❑ YES ❑ NO

DOES YOUR CHILD DO AFFIRMATIONS? ❑ YES ❑ NO

DOES YOUR CHILD WATCH MORE THAN AN HOUR OF TV PER DAY?
❑ YES ❑ NO HOW MUCH?

DOES YOUR CHILD EAT BALANCED MEALS? ❑ YES ❑ NO

DOES YOUR CHILD EXPERIENCE PROLONGED SADNESS? ❑ YES ❑ NO
EXPLAIN:

CHILD'S HEALTH HISTORY

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ ACID REFLUX	❑ CONSTIPATION	❑ FREQUENT COLDS, COUGHS, ETC.
❑ ASTHMA	❑ DIARRHEA	❑ HYPERACTIVITY
❑ BED WETTING	❑ DIFFICULT WEIGHT GAIN	❑ LEARNING DISORDERS
❑ COLIC	❑ EAR INFECTIONS	❑ SLEEPING DIFFICULTIES

CURRENT HEALTH STATUS

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).

WAS THIS THE CASE FOR YOUR CHILD? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?

❑ YES ❑ NO

PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO

PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?

❑ YES ❑ NO PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?

❑ YES ❑ NO PLEASE EXPLAIN:

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AUTHORIZATION FOR CARE OF A MINOR

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, To work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable.

PARENT OR GUARDIAN AUTHORIZING CARE SIGNATURE:	DATE: