BONN CHIROPRACTIC

Dr. Stephanie Bonn

INFANT HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

CHILDS NAME:_____ Date:_____

MOTHERS NAME:_____ PARTNERS NAME:_____

Address:_____ City:_____ Prov:_____ Postal Code:_____

Birth date: ____/____/____ Sex:_____ Home #: (_____)_____)_____ Cell #: (_____)_____
D M Y

CARE CARD #:_____ Email:_____*office records only

How did you hear about us? _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____ Number of Siblings: _____

Please check the following that apply:

Third Trimester Presentation: ___ Vertex ___ Breech ___ Transverse ___ Face/Brow

Type of birth: ___ Normal Vaginal ___ Forceps ___ Cesarean ___ Suction cap/ Vacuum

Location: ___ Home ___ Hospital

Any problems during pregnancy _____

Any problems during labor/ delivery _____

Apgar scores _____ Was Jaundice present at birth (yellow)? **Y / N** Was Cyanosis present at birth (blue)? **Y / N**

Congenital anomalies/defects? **Y / N** If yes, please explain: _____
_____

Infant feeding (please circle): Breast / Bottle **If Bottle**, which formula: _____

Average number of hours sleeping per night _____ Quality of sleep (please circle): Good / Fair / Poor

Obstetrician/Midwife _____ Pediatrician/Family MD_____

Date of last visit _____ Purpose _____

Immunization History _____

Number of doses of antibiotics your child has taken: During the past six months _____ During his/her lifetime _____

Has your child ever been treated on an emergency basis? **Y / N** If yes, please explain: _____
_____

Purpose of this appointment _____

Can your child do the following?
Please check the following that apply

_____ Respond to sound _____ Follow an object with his/ her eyes _____ Hold head up

_____ Sit alone _____Crawl _____ Stand _____ Walk alone

Has your child ever suffered from the following childhood diseases?
Please check the following that apply

_____ Chickenpox _____ Mumps _____ Measles _____ Rubella

_____ Rubeola _____ Whooping Cough _____ Other

Has this child ever suffered from the following?
Please check the following that apply

_____ Headaches _____ Behavioral Problems _____ Poor Appetite _____ ADD/ ADHD

_____ Dizziness _____ Neck Problems _____ Fainting _____ Arm Problems

_____ Stomach Aches _____ Seizures _____ Leg Problems _____ Reflux

_____ Constipation _____ Growing Pains _____ Chronic Earaches _____ Back aches

_____ Diarrhea _____ Sinus Trouble _____ Poor Posture _____ Diabetes

_____Asthma _____ Scoliosis _____ Allergies To _____ Colds/ Flu

_____ Walking Trouble _____ Colic _____ Broken Bones _____ Bed Wetting

_____ Other

Has this child ever suffered the following spinal traumas?
Fallen from… Please check the following that apply

_____ Baby walker _____ Fall from bed to couch _____ Skateboard or skates

_____ Crib _____ Swing _____ Bicycle

_____ High chair _____ Slide _____ Down stairs

_____ Change table _____ Monkey bars _____ Other

Has this child ever sustained an injury playing organized sports? **Y / N**
If yes, please explain _____

Has this child ever sustained injuries in an auto accident? **Y / N**
If yes, please explain _____

Surgery _____

Vitamins/Medications_____

Family History _____

Is there any other information that can help us care for your child?
_____

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

Parent/Guardian Signature: _____ Witness _____

It is a pleasure to welcome you to our family of happy and healthy chiropractic clients. We look forward to working towards optimal health and wellness for you and your family!

"How the twig is bent, so grows the tree"