

How many ultrasounds did you receive during your pregnancy? _____

Did you smoke, drink, or use drugs during your pregnancy? _____

Where was your child born (hospital, home, etc.)? _____

Please check all of the interventions used during the birth of your child:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Forceps | <input type="checkbox"/> C-Section | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Vacuum
Extraction | <input type="checkbox"/> Induced Labor | <input type="checkbox"/> Epidural |

Please list any complications during delivery: _____

Birth weight: _____ Birth length: _____ APGAR score: _____

Was your child born with any genetic disorders/disabilities? _____

Feeding History:

Was your child breast-fed or bottle-fed (how long)? _____

When was your child introduced to solid food? _____

Are you aware of any food allergies? _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

- | | |
|---------------------------------|-------------------|
| _____ Respond to sound | _____ Cross Crawl |
| _____ Respond to visual stimuli | _____ Stand alone |
| _____ Hold head up | _____ Walk alone |
| _____ Sit up | |

Would you consider your child to be developing at a "normal" rate? Yes/No

If no, please explain: _____

According to the National Safety Council, 50% of children fall head-first. Has this happened to your knowledge? Yes/No

Please list any impact sports that your child is/has been involved in (soccer, football, gymnastics, trampoline, cheerleading, diving, etc.): _____

Please list any car accidents, emergency room visits, surgeries, traumas, concussions, illnesses etc. that your child has been through: _____

Has your child had:

- | | | |
|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Rubella | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ |

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature

Date