McAuliffe Chiropractic Office

Infant History
2 months to 2 years

Patient's Name: _____ Parent's Name: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Sex: M F D.O.B. _____ Age: _____ SS#: _____

Reason for Today's visit? _____

When did this problem occur? _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

Nutrition

YES☐ NO☐ Is your baby breast fed? If no, how long was your baby breast fed? _____

YES☐ NO☐ Is your baby eating solid foods? _____

What foods does his/her diet contain? _____

What is your child's favorite food? _____

YES☐ NO☐ Does your child have any feeding difficulties? _____

YES☐ NO☐ Does your child have any intestinal disturbances? _____

YES☐ NO☐ Does your child have any food allergies? _____

Trauma

YES☐ NO☐ Has your child had any recent falls or traumas? _____

YES☐ NO☐ Has your child ever fallen down stairs or fallen from any height? _____

YES☐ NO☐ Has your child ever been involved in a motor vehicle accident? _____

YES☐ NO☐ Has your child ever had a bone fracture or dislocation? _____

YES☐ NO☐ Has your child had any other trauma or injuries? _____

Growth & Development

YES☐ NO☐ Can your child sit unsupported? At what age did your child start to sit-up? _____

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YES☐ NO☐ Is your child crawling yet? At what age did your child start crawling? _____

YES☐ NO☐ Is your child walking yet? At what age did your child start walking? _____

YES☐ NO☐ Does your child often trip and fall? _____

Health History

YES☐ NO☐ Has your child had colic? _____

YES☐ NO☐ Has your child has any upper respiratory infections? How often? _____

YES☐ NO☐ Has your child has asthma? _____

YES☐ NO☐ Does your child ever complain of pain in the arms or legs? _____

YES☐ NO☐ Does your child ever complain of headaches? _____

YES☐ NO☐ Has your child had any earaches? At what age did the first earache occur? ____

How frequently does your child have earaches? _____

Does your child's earache tend to occur in the same ear? Right, left, or both?

YES☐ NO☐ Has your child had any other illnesses? If yes, list: _____

YES☐ NO☐ Is your child presently receiving any medication? _____

YES☐ NO☐ Has your child ever been to the emergency room or hospital for evaluation or treatment?

YES☐ NO☐ Has your child recently been vaccinated? _____

YES☐ NO☐ Do you have any other concerns about your child's health? _____

Parent or Guardian Signature: _____ **Date:** _____