

History of Birth

Hospital / Birthing Center: Home Medical Midwife Duration of Gestation: _____ weeks

Was the birth assisted? Yes No If yes, how? Forceps Vacuum Extraction C-Section Induced Labour

Were medications given to the mother at birth? Yes No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? No Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? Yes No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? _____ Do his/her sleeping patterns seem normal? Yes No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

The father's side? _____

Do the child's siblings have any health problems? Yes No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke Yes No 2. Drink alcohol? Yes No 3. Take supplements/vitamins? Yes No

4. Take drugs? Yes No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? Yes No If yes, how many? _____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? Yes No

Was your child breast fed? Yes No If yes, for how long? _____ weeks months years

At what age was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? Yes No If yes, which ones? _____ Did your child react to them? Yes No

Has your child had antibiotics? Yes No If yes, how many courses has the child had so far & why? _____

Any pets at home? Yes No Any smokers at home? Yes No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? Yes No Any problems bonding? Yes No Does your child seem normal to you? Yes No

Does the child have any behaviour problems? Yes No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? Yes No If yes, specify: _____

Did your child go to daycare? Yes No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? Bruises Odd shaped head Stuck in birth canal Fast and/or excessively long birth

Respiratory Depression Cord around neck Other _____

Any falls/accidents during pregnancy? Yes No Has the child had any major falls since birth? Yes No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? Yes No Please explain: _____

Does your child play sports? Yes No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____ lbs Approx. Hours spent at play per week? _____ hrs