Gardiner Family Chiropractic
Child History Form

Name: _____ Date: _____

**General Information**

Was the child born: ☐at home ☐in a hospital ☐midwife present
Were any fertility treatments used for conception? ☐no ☐yes What: _____
Was ultrasound used during pregnancy? ☐no ☐yes How many: _____
Were there any invasive procedures during pregnancy such as amniocentesis or CVS?
☐no ☐yes What type? _____
Duration of Gestation: _____ weeks
Medical assistance used: ☐forceps ☐vacuum extraction ☐c-section ☐induction
Complications at birth: _____
APGAR at birth:_____ 5 minute APGAR:_____ Weight:_____ Length:_____

**Growth and Development**

Was the infant alert and responsive within 12 hours of birth? ☐yes ☐no
Explain:_____
At what age did the child achieve the following milestones:
Respond to sound _____ Follow an object visually _____ Hold up head _____
Vocalize _____ Sit alone _____ Begin teething _____
Crawl _____ Walk _____
Do the child's sleeping patterns seem normal to you? ☐yes ☐no
Explain: _____

**Chemical Stressors**

During pregnancy did mom smoke? ☐no ☐yes
During pregnancy did mom drink alcohol? ☐no ☐yes
During pregnancy did mom use any street drugs? ☐no ☐yes What: _____
Was mom ill at all during the pregnancy? ☐no ☐yes
Explain: _____
Was mom taking any medications or nutritional supplements during pregnancy?
☐no ☐yes What kind? _____
Was the child breast fed? ☐no ☐yes How Long?_____
At what age was formula introduced? _____ Type of formula used:_____
Introduction of cow's milk at what age? _____ Began solid foods at age _____
Does the child exhibit any food intolerances? ☐no ☐yes What type? _____
Are there any pets in the home? ☐no ☐yes What kinds? _____
Is the child exposed to anyone who smokes, even if they do not smoke around the child?
☐no ☐yes
Has the child needed to take any antibiotics? ☐no ☐yes How many courses? _____

Is the child currently taking any medications? ☐no ☐yes _____
_____
_____

Does the child have any allergies? ☐no ☐yes _____
_____
_____

Name: _____ Date: _____

We understand and support the fact that not all parents choose to vaccinate their children or do not follow the "recommended" vaccination schedule.

Has your child been vaccinated? ☐no ☐yes
Which vaccinations? _____
Any alteration from the "recommended" vaccination schedule? ☐no ☐yes
Explain: _____
Any adverse reactions? _____

**Psychosocial Stressors**

Did the child have any difficulties with lactation? ☐no ☐yes
Did the child have any problems with bonding? ☐no ☐yes
Has the child exhibited any behavioral problems? ☐no ☐yes
Explain: _____
Has the child had any difficulty sleeping, night terrors, or sleepwalking? ☐no ☐yes
Explain: _____
Is the child in daycare? ☐no ☐yes Age began: _____ Hours per week: _____

**Traumatic Stressors**

Was there any trauma (falls, accidents) to mom during pregnancy? ☐no ☐yes
Explain: _____
Was there any evidence of birth trauma (bruises, odd head shape, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck)? ☐no ☐yes
Explain: _____
Has the child fallen from a bed, couch, changing table, etc? ☐no ☐yes
Explain: _____
Has the child had any trauma resulting in bruises, cuts, or fractures? ☐no ☐yes
Explain: _____
Has the child ever been hospitalized? ☐no ☐yes
Explain: _____
List any sports that the child plays, age they started, and approximate hours per week.

_____
_____
_____

Does the child carry a backpack? ☐no ☐yes Weight of backpack: _____
Do you have any specific concerns about your child or chiropractic that you would like addressed? ☐no ☐yes _____
_____
_____

Signature of Parent/Guardian _____ Date _____
Print name of Parent/Guardian _____
Relationship to Child _____