WELLNESS CHIROPRACTIC

20 East Blue Hill Road
PO Box 326
Blue Hill, ME 04614
Tel: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

INFANT HEALTH SURVEY (BIRTH TO TWO YEARS)

Name: _____ Guardian: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell Pone:____-_____-_____

Email Address*:_____

Date of Birth: _____ Social Security#:_____-_____-_____ Gender: ☐ Male ☐ Female

Did the mother experience any of the following during the pregnancy?

Morning Sickness	Y N	Diabetes	Y N
High/Low blood pressure	Y N	Swollen ankles/hands	Y N
Back pain/Groin pain	Y N	Premature Contractions	Y N
Abnormal Bleeding	Y N	Did you smoke?	Y N
Were you prescribed bed rest?	Y N	Did you consume any alcohol?	Y N
Did you use any medication?	Y N	Did you have fall or a motor vehicle accident?	Y N

Birth History		**Did the mother have any of the following:**	
Time from the first regular contraction to birth:	_____	Home birth	Y N
Length of the pushing phase:		Forceps delivery	Y N
Birth weight		Vacuum extraction	Y N
Birth length		Epidural anesthesia	Y N
Apgar score: Check if unknown		Induced birth (Pitocin)	Y N
At 1 minute		Planned C- section	Y N
At 5 minutes		Emergency C-section	Y N

Was the baby?		**Baby Presentation**	
Was the baby full term?	Y N	Head presentation	Y N
Was the baby premature?	Y N	Face presentation	Y N
Was intensive care required?	Y N	Breech presentation	Y N
If so, how long was the baby in the neonatal intensive care?	_____		

WELLNESS CHIROPRACTIC

20 East Blue Hill Road
PO Box 326
Blue Hill, ME 04614
Tel: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

For Child LESS Than 6 Months:
Please indicate if your baby has or has had any of the following:

Sleeping Difficulties	Y N	Nursing/eating difficulties	Y N
Preferred feeding position (side)	Y N	Spits up after feeding	Y N
Cries a lot	Y N	Has intestinal gas	Y N
Has constipation or diarrhea	Y N	Had any trauma (Fall or was in a motor vehicle accident)	Y N
Surgeries	Y N	Birth Defect	Y N

For Child MORE than 6 months:
Please indicate if your baby has or has any of the following:

Sleeping difficulties	Y N	Has tubes in the ears	Y N
Eating difficulties	Y N	Trips and falls easily	Y N
Digestive problems (constipation, diarrhea, upset stomach)	Y N	Had any trauma (fall or was in a motor vehicle accident)	Y N
Had colic as an infant	Y N	Had injuries (cuts, burns, fractures, joint sprain)	Y N
Has frequent colds	Y N	Surgeries	Y N
Has ear infections	Y N	Birth Defect	Y N

Nutrition:
Please indicate if your child has received any of the following:

Breast milk- how long?_____	Y N	Solid food	Y N
Cow's milk	Y N	At what age was solid food	
Goat's milk	Y N	introduced?	
Soy milk	Y N	What was introduced first	
Fruit juices	Y N	Vitamins/ supplements	Y N
Vegetable juices	Y N	Medications	Y N

WELLNESS CHIROPRACTIC

20 East Blue Hill Road
PO Box 326
Blue Hill, ME 04614
Tel: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

Immunization Status:

☐ **Choosing not to immunize** ☐ **All up to date and current**

List the immunizations your child has received and any reaction you have observed:

Date	Immunization	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Health Care

Name of Pediatrician: _____ Date of last exam: _____
Name of Chiropractor: _____ Date of last exam: _____

Is your child under medical care for a specific condition? If so please list the condition and the care received:

_____
_____

Other information not listed above: _____
_____
_____