

INFANT/CHILD HISTORY FORM

Date: _____
Patient's full name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
Name of parent or guardian: _____ Phone: () _____
Height: _____ Weight: _____ Number of siblings: _____ Right or left handed: R L
Number of hours of sleep per night: _____ Quality of sleep: Good Fair Poor
Name of Pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Previous D.C.: _____ Date of last visit: _____
Reason for visit: _____

CHIEF COMPLAINT

Reason for visit today? _____
Other treatment for this condition including any medications given: _____

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize Seim Chiropractic Center, Dr. Richard Seim, Dr. Linda Seim to administer care, as they so deem necessary to my son/daughter/ward.

Signed: _____ Date: _____

HISTORY OF COMPLAINT

Date of Onset: _____ Sudden or gradual? _____
Duration of problem: _____ Minutes Hours Days Weeks Months Years
Pattern of pain or problem: Constant Intermittent Occasional
Cause of problem if known: _____
What makes it better? _____
What makes it worse? _____
Effects of problem on body function and daily activities: _____

PRENATAL HISTORY

Duration of gestation: _____ weeks Pregnancy normal? _____
List any significant complications during pregnancy: _____
Was delivery normal? _____ Were drugs used during delivery? _____
List any complications of delivery: _____
Were forceps used? Yes No Place of delivery: Home Birthing Center Hospital
Apgar score at birth: _____ At five minutes: _____
Birth weight: _____ pounds _____ ounces Length: _____ inches

DEVELOPMENTAL HISTORY

Was the infant alert and responsive within twelve hours of delivery? Yes No
At what age did the child: respond to sound-_____ hold head up-_____ sit alone-_____
crawl-_____ stand-_____ walk alone-_____

NUTRITIONAL HISTORY

Breastfed? Yes No If yes, for how long? _____ months If no, formula type: _____
Cow's milk began age _____ Began solid food at age _____

SOCIAL BEHAVIOR

Child seems normal for age? Yes No If no, explain _____

CHILDHOOD DISEASES

Circle any that child has had: Chickenpox, mumps, measles, rubella, rubeola, whooping cough.
Has the child been immunized? Yes No If yes, any adverse reactions? _____
List any significant family history such as cancer, diabetes, heart disease, etc. _____
