

Date \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**Supplemental Infant/Child Assessment Form**

Place of birth:  Home  Birthing Center  Hospital  Other, please list: \_\_\_\_\_

Type of Birth:  C-section  Vaginal

Was ultrasound used during pregnancy?  Yes  No If yes, how many times: \_\_\_\_\_

Was labor induced?  Yes  No If yes, why: \_\_\_\_\_

Was Anesthesia used?  Yes  No Type(s) of Anesthesia use: \_\_\_\_\_

Was there any notable Doctor assisted birth trauma?  Twisting or Pulling  Vacuum Extraction  Forceps  Other: \_\_\_\_\_

Were there any special medical procedures or tests performed?  Yes  No If yes, please list: \_\_\_\_\_

Was the child breast fed?  Yes  No If yes, to what age: \_\_\_\_\_

According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life.

Can you recall ANY jolts, falls, or traumas to this child?  Yes  No If yes, please describe: \_\_\_\_\_

Has this child experienced any fractures or dislocations?  Yes  No Please describe: \_\_\_\_\_

Other than the time spent sitting in a classroom, does your child spend prolonged time sitting?  Yes  No

Which activities does this child participate in?  Soccer  Football  Gymnastics  Karate  Hockey  Basketball  
 Video Games  Dance  Wrestling  Baseball  Softball  Cheerleading  Other: \_\_\_\_\_

How would you rate your child's overall diet?  Poor  Somewhat Healthy  Healthy

Please mark any of the following conditions your child has experienced:  Colic  Irregular Sleeping Patterns  Nightmares  
 Seizures  Tantrums  Ear Infections  Allergies  Asthma  Headaches  Poor Digestion  Repeated Infections  
or Colds  Bed Wetting  Learning Disorders  Emotional Disorders  ADD or ADHD  Other: \_\_\_\_\_

Please list all medications your child has been treated with since birth: \_\_\_\_\_

Were you informed of any adverse reactions to any of the above listed medications?  Yes  No

**Authorization**

I hereby authorize the Doctors and Staff at HealthFirst to examine and treat my  Son  Daughter. Having carefully read the attached informed consent, I hereby give my informed consent to have chiropractic treatment administered.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_