Cheatwood Chiropractic
303 Bryan Rd. Ste 2, Brandon, FL 33811 813-681-4418

INFANT/CHILD HEALTH HISTORY FORM

Today's Date_____ Parents' Names:_____
First Name_____Last Name_____ Birth Date___/___/___ Age___
Male___ Female___ Number of Siblings_____ SS#_____
Address_____City_____State_____Zip_____
Phone#_____ Who may we thank for referring you?_____

If your child has no symptoms or complaints, and is here for wellness services, please check here_____
Reason for consulting our office_____
Other professionals seen for this problem: (Chiropractor/Medical Doctor/Midwife/Lactation Consultant/Specialist)_____
Medications child is taking or surgeries child has had:_____

Answering the following questions will help us assess possible challenges to your child's health:

Pregnancy:
Were there any complications or high risk factors to the pregnancy? No__ Yes_____
How long was the pregnancy?_____
Was Mom on any medications-prescription or OTC?_____Smoke during pregnancy? No__Yes__
Was baby ever in the Breech position? No___Yes_____
How many UltraSounds were performed?_____
Birth and Delivery:
Where was the baby born? Home____ Birthing Center_____ Hospital_____ Other_____
Was the delivery: Vaginal___ C-Section___ Devices used? Forceps___ Vacuum___ Reason for C-section_____
Was oxytocin/Pitocin used?No___Yes___ Was an epidural administered?No___Yes___
Any complications that baby experienced during or after birth? No___Yes_____
Baby's birthweight_____ Length_____
Feeding History:
Breast fed? Yes___(Until what age?___) No___ Formula fed? No___ Yes___What type?_____(until age?_____)
Any feeding challenges?No___Yes_____ Latching challenges?No___Yes_____
Any tongue or lip tie?No___Yes___ Revisions?_____
Infancy:
Has child been vaccinated? No___ Yes___Which ones?_____
Any prolonged use of medications or inalers? No___Yes_____
Did the infant suffer any trauma such as serious falls or car accidents? No___ Yes_____
Childhood Years:
Any Childhood diseases? No___Yes___which ones?_____
Recurrent infections?No___Yes_____
Play any youth sports? No___Yes_____
Any developmental issues? No___ Yes_____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian hereby grant permission for my child to be evaluated and to receive chiropratic care if warrented.
Signed:_____ Date:_____