

**COMPLETE THIS PAGE FOR CHILDREN INFANT TO 3 YEARS OF AGE**

**PRENATAL HISTORY**

DURING PREGNANCY DID YOU USE:  
 DRUGS/MEDICATIONS       TOBACCO/ALCOHOL  
 IF YES, PLEASE EXPLAIN:

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LOCATION OF BIRTH:  
 HOME       BIRTHING CENTER       HOSPITAL

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DESCRIBE YOUR DELIVERY:  
 LABOR WAS CHEMICALLY INDUCED       LABOR WAS DOCTOR ASSISTED  
 C-SECTION DELIVERY       FORCEPS/VACUUM EXTRACTION  
 DOCTOR PULLED OR TWISTED BABY       PREMATURE DELIVERY  
 PLEASE EXPLAIN:

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HOW LONG WAS THE LABOR FROM THE FIRST REGULAR CONTRACTIONS TO THE BIRTH?  
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HOW LONG WAS THE 2ND STAGE (THE PUSHING PHASE) OF LABOR?  
 \_\_\_\_\_

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DESCRIBE ANY COMPLICATIONS EXPERIENCED DURING DELIVERY:

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DID YOU EXPERIENCE ANY ILLNESS(S) WHILE PREGNANT?  
 YES       NO  
 PLEASE EXPLAIN:

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PLEASE DESCRIBE ANY GENETIC OR DISABILITIES:

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BIRTH WEIGHT:  
 \_\_\_\_\_

BIRTH LENGTH:  
 \_\_\_\_\_

APGAR SCORES:    AT 1 MIN \_\_\_\_\_ /10      AT 5 MIN \_\_\_\_\_ /10

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ULTRASOUND DURING PREGNANCY?     YES       NO      NUMBER: \_\_\_\_\_

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DID YOU BREASTFEED THE BABY?       YES       NO  
 IF YES, HOW LONG?

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DID YOU FORMULA FEED THE BABY?       YES       NO  
 IF YES, HOW LONG?

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AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:  
 \_\_\_\_\_

COW'S MILK:  
 \_\_\_\_\_

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ARE YOU AWARE OF ANY FOOD OR JUICE ALLERGIES OR INTOLERANCE?  
 YES       NO

**CHILD'S CURRENT HEALTH STATUS**

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS?     YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN HOSPITALIZED?     YES       NO  
 PLEASE EXPLAIN:

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THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E.: BED, CHANGING TABLE, STAIRS, ETC.).  
 WAS THIS THE CASE FOR YOUR CHILD?       YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT?     YES       NO  
 PLEASE EXPLAIN:

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HAS YOUR CHILD EVER HAD SURGERY?       YES       NO  
 PLEASE EXPLAIN:

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DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?  
 YES       NO  
 PLEASE EXPLAIN:

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HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR?  
 YES       NO  
 PLEASE EXPLAIN:

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WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED?

**CHILD'S HEALTH HISTORY**

**INSTRUCTIONS:** *Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FREQUENT COLDS, COUGHS,
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> HYPERACTIVITY
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> DIFFICULT WEIGHT GAIN	<input type="checkbox"/> LEARNING DISORDERS
<input type="checkbox"/> COLIC	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> SLEEPING DIFFICULTIES