INFANT HISTORY
(2 months to 2 years of age)

Date: ___/___/_____
Name of child: ____________________________ Sex: M F Birthday: ___/___/____ Age: ___

The following questions are designed to help the doctor provide the best possible spinal care for your child.

Is your child being breast fed? ☐ Yes ☐ No If no, for how long was he-she breast fed? _________
If still breastfeeding, how much cow's milk does the mother consume each day? ________________

Yes No

☐ ☐ **Is your child formula fed? ________ What Brand? _____________________________**
☐ ☐ **Is your child feeding solid food? _______ What foods does his-her diet contain? ____Favorite Food? ______________**
☐ ☐ **Does your child have any feeding difficulties? ______________________________**
☐ ☐ **Does your child have any digestive disturbances? ____________________________**
☐ ☐ **Does your child have any food allergies? ____________________________________**
☐ ☐ **Does your child have any persistent or intermittent skin rashes? ______________**
☐ ☐ **Is your child receiving any vitamin supplements? ____________________________**

TRAUMA

☐ ☐ **Has your child had any recent falls or trauma? _______________________________**
☐ ☐ **Has your child ever fallen downstairs or fallen from any height? ________________**
☐ ☐ **Has your child ever been in a motor vehicle collision? _________________________**
☐ ☐ **Has your child ever had a bone fracture for joint dislocation? __________________**
☐ ☐ **Has your child had any other trauma or injuries? _________________________**
☐ ☐ **Does your child ever bang his or her head repeatedly against a wall, bed or other object? Y N ____**

GROWTH – DEVOLPMENT – HEALTH HISTORY

☐ ☐ **Can your child sit unsupported? ___ ____**
☐ ☐ **Has your child had any upper respiratory infections? _________________________**
☐ ☐ **Has your child had asthma? ____**
☐ ☐ **Does your child ever complain of back or neck pain? ___________________________**
☐ ☐ **Does your child ever complained of pains in the arms or legs? __________________**
☐ ☐ **Does your child ever complain of headaches? ________________________________**
☐ ☐ **Has your child had any earaches? ____**
☐ ☐ **How frequently does your child have earaches? ______________________________**
☐ ☐ **Do the earaches tend to occur in the same ear? ______________________________**
☐ ☐ **Has your child had any other illnesses? _____________________________________**
☐ ☐ **Is your child presently receiving any medications? ____________________________**
☐ ☐ **Has your child been recently vaccinated? ___________________________________**

☐ ☐ **Do you have any other concerns about your child's health? ____________________**

__________________________ ____________________
Parent/Guardian's Signature **Relationship to Child**