



Priority Chiropractic

531 Bayfield St., Barrie, ON, L4M 4Z9

Infant Case History

(please fill out as completely as possible)

Parent's Name: _____

Infant's Name: _____

Date of Birth: Day _____ Month _____ Year _____

Weight at Birth: _____ Length at Birth: _____ APGAR Score: _____

Place of Birth: _____

Current Weight: _____ Current Length: _____

Is this visit for a particular complaint, or for a general chiropractic evaluation? _____

Please tell us about your pregnancy.

Length of pregnancy (circle): pre-term___weeks term post-term___weeks

Weight gain during pregnancy: _____ pounds

Medications/Drugs Y N

Vitamins/ Supplements Y N

Tobacco/Alcohol Y N

Ultrasounds Y N

Amniocentesis Y N

if yes how many? _____

Illnesses during pregnancy

Toxicity

Gestational diabetes

Elevated blood pressure

Prescribed bed rest

Other: _____

Vomiting

Malnutrition

Infections

Bleeding

Labour and Delivery:

Length of hard labour: _____ hours

Position of infant (if known): normal vertex breech transverse lie

Chemically induced labour Y N

Doctor assisted labour Y N

C-section Y N

Forceps Y N

Vacuum extraction Y N

Epidural or other anesthetic Y N

Length of hospital stay _____



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Since Birth:

Nursing normally from both breasts	Y	N	
Number of wet diapers per day	_____		
Number of dirty diapers per day	_____		
Jaundice	Y	N	
Feeding problems	Y	N	
Sleeping problems	Y	N	
Colic	Y	N	
Vaccinations	Y	N	if yes, which ones and when
Other:	_____		
Explain:	_____		

Other Conditions:

Falls	Y	N	
Respiratory problems	Y	N	
Infections	Y	N	
Antibiotic use	Y	N	
Other testing	Y	N	
Hospitalizations	Y	N	
Any known congenital abnormalities	Y	N	
Explain:	_____		

When did the following milestones occur (if applicable)?

1. Lifts Head	_____	6. Imitates sounds	_____
2. Smiles	_____	7. Crawls/pulls self up	_____
3. Vocalizes	_____	8. Stands on own	_____
4. Rolls over	_____	9. Walks	_____
5. Reaches for objects	_____	10. Walks up stairs	_____

Family Health Information: Many health problems are the result of hereditary spinal weaknesses. Information about your family members will give us a better picture of your total health. Please list your immediate family members who have had **any** type of illness or disease.

Name	Relationship	Past and Present Health Problems

Date: _____

Signature of Parent/Guardian: _____