Wellness for You NOW Chiropractic

Dr. Joseph Manza, DC, CACCP

We are honored and blessed that you have chosen our office to serve your family.
Please know that we will care for your children with the greatest respect and tenderness.

INFANT HISTORY Newborn to 11 months

Child's Name_____Birthdate_____ Sex: M F

Address_____City_____Zip_____

Parent's Names_____

Parent's Phone_____Work#_____

Email_____

Siblings and ages_____

Pediatrican_____#_____

Whom may we thank for referring you to our office? _____

REASON FOR TODAY'S VISIT: _____

Does your child appear to be in pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ____ Sudden ____ Gradual Is the problem: ____ Constant ____ Intermittent

Has your child ever had this problem before? Yes No If Yes:_____

Has your child previously been treated for this problem? Yes No By whom? _____

Has your child previously had chiropractic care? Yes No By whom? _____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Hospital birth	Yes	No	_____
Home birth	Yes	No	_____
Midwife Assisted	Yes	No	_____
Vaginal Delivery	Yes	No	_____
Planned C-section	Yes	No	_____
Emergency C-section	Yes	No	_____
Was birth induced	Yes	No	_____
Forceps delivery	Yes	No	_____
Vacuum extraction	Yes	No	_____
Anesthesia administered	Yes	No	_____
Fetal Distress	Yes	No	_____
Meconium staining	Yes	No	_____
Head presentation	Yes	No	_____
Face presentation	Yes	No	_____
Breech presentation	Yes	No	_____

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BABY'S CONDITION IMMEDIATELY AFTER BIRTH (answer to the best of your ability)**:**

Apgar Scores: At 1 minute _____/ 10 At 5 minutes _____/ 10 Unknown

Birth weight _____ lbs/kgs Birth Length _____ ins/cms Baby home on day _____

Baby's Crying: _____ Cried immediately after birth _____Weak Cry
_____ Cried strongly Did not cry for _____ minutes

Baby's Color: _____ Pink all over _____ Blue face _____ Blue hands/feet

Baby's Activity: _____ Arms and legs actively moving _____ Floppy baby

Was the baby put in intensive care? Yes No If yes, what was the reason and how long were they in for?
_____

Was any medication given at birth? _____

Did you choose to vaccinate your child? Yes No If "Yes", check all vaccinations the child has received.
___ DPT ___MMR ___Chicken Pox ___Hepatitis Other_____
_____

Describe any and all reactions to vaccine(s). _____
_____

It has been shown that in the first year of their life 47.5% of babies have a significant fall. If your child falls into this category please briefly explain the incident:_____
_____

BABY'S CURRENT HEALTH STATUS:

How many hours does your baby sleep between feeds? During day _____ At night _____

Does your baby go to sleep easily? Yes No If No _____

Does baby have a preferred sleeping position? Yes No Position: _____

Does baby cry if you change this sleeping position? Yes No

Does baby have any feeding difficulties? Yes No If Yes_____

Is baby being breast-fed? Yes No If no, how long was baby breast-fed _____ weeks/months

Does baby have a one sided breast preference? Yes No Preferred breast: Left / Right

Is baby formula fed? Yes No Formula name or other milk source? _____

Does baby frequently spit-up after feeding? Yes No If Yes_____

Does your baby cry a lot? Yes No For how many hours each day? _____

Does baby pass a lot of intestinal gas? Yes No

Does baby have a preferred head position? Yes No If Yes_____

Does baby frequently arch his/her head and neck backwards? Yes No

Does baby cry or become irritable during a diaper change? Yes No

Has baby ever had a fever? Yes No

Has baby had any falls? Yes No If Yes_____

Has baby been in a car accident or near miss? Yes No If Yes_____

Has baby had any other trauma? Yes No If Yes_____

Do you have any other concerns? Yes No If Yes_____
_____

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