Absolute Wellness Center
Chiropractic Care for Your Mind, Body, & Soul!

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The pregnancy history is the blueprint for your child's development. Please take the time to complete the history. In cases of adoption, please provide any information available.

Infant History 0-12 month

Exam Date:_____

Child's Name: _____Child's DOB: _____

Parent's Name: Mom: _____Dad: _____

Age of Mom during Pregnancy_____ Age of Dad during Pregnancy_____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Number: _____

Email: _____

What are you main concerns with your child? (Please be as detailed as you can be)

_____

_____

History of trauma? Yes No _____

_____

History of surgeries or hospitalizations? Yes No _____

_____

Have you had any testing performed on your child? (labs, scans, x-rays, etc) Yes No

_____

Did you have a written Birth Plan? Yes No

Did you receive prenatal care from an: Ob/Gyn Midwife Both

Name of provider_____

Was this a planned pregnancy? Yes No

Did you plan to breast feeding? Yes No How long? _____

Any complications with breast feeding? Yes No Please explain:

_____

Pregnancy term (40 weeks) _____

Delivery Venue: Hospital Birthing center home:_____

Type of delivery: Vaginal Cesarean section

Were any instruments used in delivery? Forceps/Vacuum/Other _____

_____

During your pregnancy did you experience body pains? _____

_____

During your pregnancy did you receive any medical diagnosis? _____

_____

During your pregnancy did you experience any emotional stress? If so which trimester?

_____

_____

Identify any areas of pain (circle all that apply)

Neck Mid Back Low Back Ribs Arms/Hands Legs

Structural Notes:

_____

_____

Pregnancy weight gain: _____

Identify any diagnosis you received during pregnancy (circle all that apply)

Gestational Diabetes	High Blood Pressure	Low Blood Pressure
Pre-Eclampsia	Eclampsia	Protein in Urine
Urinary Infection	Pelvic Inflammatory Disease	Complete Bed Rest
Swollen Ankles	Anemia	Seizures
Heart Problems	Indigestion	Thyroid Problems
Infections	Placenta Misplaced	Abnormal Bleeding
Medications	Yeast Infections	Other Illness (please explain) Any Hospitalization

How was your diagnosis managed?

_____

_____

Did you choose to perform In-Utero Testing? Yes No (Please list tests)

_____

Did you have an ultrasound during your pregnancy? Yes No How many? _____

Did you have any x-rays during your pregnancy? _____ Reason: _____

Did you experience any of the following: (please circle all that apply)

Fatigue	Shaky with missed meals
Irritability before meals	Headaches with physical and mental stress
Eating to relieve fatigue	Weak Immune
Cannot fall/stay asleep	Allergies
Dizziness from moving down up	Slow to start in a.m.
Spells of dizziness	Gastric Ulcers
Asthma	Afternoon headaches
Hemorrhoids	Feeling full/bloated
Varicose veins	Craving sweet, caffeine, cigarettes
Unstable behavior	Blurred vision
Frequent Urination	Any Blood in Stool/Urine
Frequent Bowel Movement	Increase/Decrease in Precocious Symptomatology
Diarrhea	Energy Boosts
Hard/Loose Stool	Gestational Depression
Irritation	Mood Swings
Fears	Cravings
Avoidances	Fear of childbirth
Post natal Depression	Feeling tired or sluggish
Feeling cold-hands, feet, all over	Constipation
Requires excessive amounts of sleep	Weight gain despite efforts
Gain weight easily	Infrequent bowel movements
Outer 1/3 of eyebrow thinned	Thinning of hair on scalp, face, genitalia
Dryness of skin and/or scalp	Mental sluggishness
Depression and lack of motivation	Morning headaches resolving throughout the day

During your pregnancy did you use any of the following?
Tobacco Products? Yes No Alcohol? Yes No

Non-Prescribed Drugs? Yes No List:_____

Prescribed Drugs? Yes No List:_____

Did you take prenatal vitamins? Yes No List:_____

Where did you get your prenatal Vitamins?_____

Did you take any additional vitamins? Yes No List:_____

Did you experience any cravings? Yes No (List cravings) _____

_____

Did you experience any avoidances? Yes No (List avoidances) _____

_____

Did you experience morning sickness? Yes No How long?_____

Did you experience any personal emotional stress during your pregnancy? Yes No

Identify subject, detail of stress _____

_____

Were you supported through your pregnancy (family, spouse, friends) Yes No ____

_____

Did you enjoy being pregnant? Yes No _____

Did you attend any Birth Classes? Yes No Which one(s)?

_____

_____

Were you exposed to any unusual fumes or other chemicals during your pregnancy?

_____

_____

Do you have any silver amalgams (fillings)? _____

Where did you live when you conceived this child? _____

Are you vaccinated? _____ When was your last vaccine? Identify_____

_____

Birth History

Length of Labor (Time): _____

Birth Outcome: (circle)

Vaginal: Natural Induced
Medications _____
Manual _____

Cesarean Section: Planned or Emergency

Instruments used: Vacuum Extraction Forceps Epidural Episiotomy

Any Complications (Please Explain)?

_____

_____

_____

Neonate Position (Circle): Breech Face Up Face Down

Cord around neck Arm/Leg Malposition

Cord Cut: Immediately After ____ Minutes

After giving birth did you experience any of the following: Depression

Mood Swings Fatigue Energy Boost Irritability Infection

Neonate Immediately After Birth

APGAR Score: _____ 1 minute _____ 5 Minutes _____

Comment on low score(s): Heart rate, Breathing, Grimace, Activity, Appearance:_

_____

Neonate cried immediately after birth: Yes No

Strength of Cry: Weak _____ Did not cry for ____ minutes.

Was intensive care necessary for neonate?_____

_____

_____

Did you plan to breastfeed? Yes / No (circle)

Was the neonate fed formula in nursery (venue: hospital) Yes No

Was the neonate ever fed formula: Yes No

Was the formula soy base: Yes No

Vaccines Administered: Yes No Which ones? _____

_____

Vitamin K: Yes No PKU: Yes No

Birth weight: _____lbs/kgs _____oz

Birth Length _____inches/centimeters

Head Circumference: _____

Was your male neonate circumcised? Yes No

Birth to 12 months

At what age did your infant erupt their first tooth?_____

At what age did your infant begin solids?_____

What were your infant's first solids?_____

What did your infant's diet consist of (give an example of breakfast, lunch and dinner)?

_____

_____

_____

_____

Describe your infant's first year of health (circle and describe all that apply and how they were managed):

Ear Aches	Teething Problems	Rashes
Eczema	Yeast Infections	Diarrhea
Constipation	Chronic Colds/Flu	Low muscle Tone
Intussusception	Inconsolable	Clingy
Irritable	Interrupted Sleeping Patterns	Cranial Issues
Delayed Motor Skills	Did Not Smile Easily	Sound Sensitivities
Food Sensitivities	Picky Eater	Tongue Tied
MTHFR susceptibility	Genetics	

Please describe anything that is missing from the list above. Provide details.

_____

_____

Has your infant received an H1N1 vaccine? Yes No Injection or Nasal Spray

Date Administered _____

Are you concerned about a vaccine reaction? Yes No

Newborn Developmental Milestones (check all that apply)

Gross Motor Skills
□ 4 weeks Holds head momentarily
□ 3 mths Head and shoulder supported by forearms
□ 4 mths Infant pulled to sitting position by hands
□ 6 mths sits unsupported in the upright position
□ 6 mths head and shoulder supported by arms
□ 6 mths rolls from face up to face down
□ 9 mths crawls
□ 9 mths stands holding onto furniture

Fine Motor Skills
□ At birth grasp reflex present
□ 4 mths holds and shakes a rattle
□ 5 mths grasps objects indepently
□ 6 mths moves an object from one hand to the other
□ 6 mths explores objects in the mouth
□ 6 mths self feeding, holds and eats finger food
□ 12 mths picks up object with thumb/index finger

Social Skills
□ 2 mths Smiles
□ 3 mths Reaches for familiar objects
□ 4 mths Plays with hands
□ 6 mths Plays with feet
□ 9 mths Expresses joy/pleasure
□ 12 mths Feeds self using fingers

Communication Skills
□ 7 weeksMakes cooing sounds
□ 3 mths Laughs
□ 5 mths One syllable - "da"
□ 8 mths Two syllable – "da da"
□ 12 mths Uses 2 to 3 words

Adaptive Skills
□ 10 mths Uses a cup unassisted
□ 12 mths Holds own bottle