Wetaskiwin
Family Chiropractic
Complete Lifestyle & Alternative Healthcare

Welcome

ABOUT YOUR INFANT

Today's Date: ______________________ Name: ____

Date of Birth: mm/dd/yyyy __________________________ Age: __________ ☐ Male ☐ Female

Alberta Health Care Number: _________________ Present Height: ___________ Present Weight: ___________

Alberta Blue Cross ID Number: ________________________________ Group Number: __________________

Mother's/Father's Name: ____

Address: ____ City: ___________________________

Province: _________________ Postal Code: ____________ E-mail: _____________________________

Phone: (H)______________________________ Bus/Cell: _______________________________________

Emergency Contact: ______________________________________ Phone: ___________________________

How did you hear about our clinic? ____

REASON FOR VISIT

What is your main reason for contacting us? ____

When did this condition begin? ____

List other care undergone for this complaint, including medication: _____________________________________

Other health concerns: ____

Pregnancy & Birth History:

Please indicate and explain any of the following which apply:

		If Yes, please explain
Mothers illness during Pregnancy:	☐ Yes ☐ No	____________________
Supplements taken during pregnancy:	☐ Yes ☐ No	____________________
Medications taken during pregnancy:	☐ Yes ☐ No	
Ultrasound done during pregnancy & reason:	☐ Yes ☐ No	____________________
Invasive procedures: i.e. amniocentesis, CVS	☐ Yes ☐ No	____________________
Trauma during pregnancy i.e. falls, accidents	☐ Yes ☐ No	____________________
Complications during birth:	☐ Yes ☐ No	____________________
Assisted birth: i.e. forceps/vacuum/c-section/induce	☐ Yes ☐ No	____________________
Birth trauma: i.e. bruises/odd shaped head/ cord around neck	☐ Yes ☐ No	____________________
Medication given to mother during birth:	☐ Yes ☐ No	____________________

Duration of gestation: __________________ weeks Duration of birth: ______________________

Setting of birth: ☐ Hospital ☐ Home ☐ Birthing Centre ☐ Midwife

APGAR at birth: ____________ After 5 minutes: ________ Birth weight: __________ Birth length: __________

ADDITIONAL HEALTH INFORMATION

Growth & Development:

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain: ______________________________

Sleeping pattern seems normal? ☐ Yes ☐ No If no, explain: ______________________________

Any health problems (cancer, diabetes, heart disease etc.) in the family? ☐ Yes ☐ No

If yes, please explain: ______________________________

Feeding & Nutritional History: *(fill in only what is applicable)*

Was/Is the infant breast fed? ☐ Yes ☐ No If Yes, for how long? ______________________________

Food Introduction	Age	Type	Difficulties (spitting up, colic, diarrhea, not latching, not eating from R/L breast)
Formula			
Cow's Milk			
Baby Food			
Solid Foods			

Environmental Stressors:

Any vaccinations received? ☐ Yes ☐ No Specify: ______________________________

Any illnesses requiring antibiotics? ☐ Yes ☐ No Explain: ______________________________

Total number of courses of antibiotics to date: ______________________________

Any difficulties with lactation? ☐ Yes ☐ No Explain: ______________________________

Any problems bonding? ☐ Yes ☐ No Explain: ______________________________

Any pets at home? ☐ Yes ☐ No Specify: ______________________________

Any smokers in the home? ☐ Yes ☐ No How much: ______________________________

ROS - For Doctors Use Only

1. GENERAL: Weight changes, energy level, sleep pattern, growth patterns, fever, fatigue.

2. SKIN: Birthmarks, rashes, pallor, sweating, itching, bleeding, swelling, dryness, colour changes, lumps, changes in hair/nails

3. HEAD: Headaches, head injuries, dizziness

4. EYES: Vision disorder, pain, redness, excessive tearing, glasses

5. EARS: Hearing disorder, infections, dizziness, ringing in ears

6. NOSE & SINUSES: Frequent colds, nasal stuffiness, hay fever, nose bleeds, drainage, discharge, sinus troubles

7. MOUTH/THROAT: Dental/gum issues, sore throat, speech problems, hoarseness, sore enlarged tongue, last dental exam

8. LYMPHATICS: Enlarged/painful lymph nodes