Country Hills Chiropractic & Wellness

BABY CARE CONSULTATION FORM (0-2 years)

Alberta Health Care # __/__/__/__/__/__ - __/__/__/__

Full Name _____ Birth Date _____ /____/ _____
dd / mm / yy

Mother's Name _____ Father's Name_____

Address_____Postal Code _____

Phone (res) (____) _____ Phone (cell) (____) _____ Phone (cell) (____)_____

Age _____ Height _____ Weight _____ Number of Siblings _____

Birth Weight_____Current Weight _____ Birth Length _____ Current Length _____

Reason for Baby's visit _____

Previous surgery, illness or accidents _____

Baby spends most of the waking hours with? _____

Is baby exposed to tobacco smoke on a daily basis? _____

Name of family physician _____

Has baby had previous chiropractic care? _____ Doctor's Name _____ Last Visit _____

Who referred you or how did you hear about our clinic? (circle one and please specify name)

Family Member Friend Physician Phone Book _____
name

I realize that Alberta Health Care Insurance Commission will not pay the Doctor's fee schedule and that I am personally responsible for payment. I further understand that I am responsible to submit my own claim through my insurance company if I have personal coverage.

If this is an auto accident case I understand that I am responsible for all debts incurred at this clinic which are due and payable after each visit unless special arrangements have been made with my insurance company.

_____ _____
Signature of Parent or Guardian (signifying the above to be true) Date

MOTHER'S CARE DURING PREGNANCY

The completion of this record allows for you and your baby to have an information base that is as important to you as it is to your doctor: Please be as accurate as possible in your answers!

1. Cigarettes: a) Has never smoked b) No longer smokes c) Quit smoking during pregnancy d) Continued smoking regularly (if yes, how much?) _____
2. Alcohol: NONE____ YES____ if yes, how much? _____
3. Medication: NONE____ YES____ if yes, how much & what? _____
4. Other drugs: NONE____ YES_____ if yes, how much & what? _____
5. Mother's and/or Child's problems DURING pregnancy: NONE____ YES____ if yes, please explain: _____
6. Was pregnancy full term? YES____ NO____ If no, when was delivery? _____
7. Place of birth: a) Home b) Hospital c) Birthing center d) Other _____
8. Birthing assisted by: a) Obstetrician b) G.P c) Midwife d) Other _____
9. Manner of birth: a) Normal Vaginal b) Forcep Assisted c) Cesarean
10. Labour was: a) Average b) Easy c) Prolonged d) Extremely rapid
11. Problems encountered during labour/delivery? NONE____ YES____ if yes, please explain _____
12. Did your newborn have any difficulty starting to breathe? YES____ NO_____
13. Did your newborn have any jaundice? YES_____ NO_____
14. Have you ever lost an infant to S.I.D.S, early stroke or other causes? NO_____ YES_____
15. INFANT FEEDING:
    - Breast Fed: YES____ NO____ if yes, how long? _____
    - Formula: YES____ NO____ if yes, type? _____
    - Solids: When did you start? _____
    - Additional Supplements: _____
16. Are there any problems in the feeding schedule: YES____ NO____
17. History of colic: YES____ NO____ if yes, what time is the crying most intense? _____
18. Number of hours of sleep per night: _____ Time put down for the night: _____
19. Quality of sleep: a) good b) Fair c) Poor d) Restless e) Fussy
20. Baby sleeps: a) In a crib in separate room b) In crib in parents room c) In bed with parents

21. Is the baby's urine straw coloured: YES____ NO____ if no, explain

22. Are the baby's bowel movements regular: YES____ NO____

23. Are bowel movements of a yellowish colour and toothpaste consistency: YES____ NO____ if no, explain _____

24. Does your baby normally feel stiff on being picked up? YES____ NO____

25. Does your baby have any history that may be considered unusual? NO____ YES____ if yes, please explain _____

26. Place a check mark beside any of the following that are a concern:
    Recurrent eye infection____ Digestive problems____ Congested breathing____
    Recurrent ear infection____ Sluggishness____ Mouth breathing____
    Recurrent throat infection____ Restlessness____ Grasping skills____
    Eye focus skills____ Others_____

27. Are there any hereditary conditions in your family (mother or father) that may affect your baby's health: NO____ YES____ if yes, please explain_____

28. State approximate age when the following activity took place: (if applicable)

a) Sat up_____ b) Crawled_____ c) stood-with support_____without support_____
d) walked_____

29. Has your baby had any of the following: (circle and note age and problem)

a) Childhood disease_____ b) High fever _____ c) Reaction to immunization shots_____ d) Reaction to medication_____

30. Name of Pediatrician and/or G.P_____

31. Date of last visit to G.P_____ Pediatrician_____
Purpose_____

32. Are you following an infant immunization program? YES____ NO_____

33. Has your infant been treated on an emergency basis? NO____ YES____ if yes, please explain_____

34. Has your baby been examined by a specialist other than a Pediatrician? NO____ YES____ if yes, by whom_____

Thank you for completing this form!