Natural Living
CHIROPRACTIC & ACUPUNCTURE

Additional Health Information for Pediatric Patients

(Age 6 and Younger)

Child's Name: _____ Birth Date:_____

Parent's Names: _____

Has your child been under medical care? If so, for what condition and for how long?

_____

Medications and/or supplements?

_____

Surgeries? (include dates) _____

Problems during pregnancy? _____

Presentation at birth:

- ☐ Vertex
- ☐ Breech
- ☐ Transverse
- ☐ Face or Brow

Problems during labor/delivery? _____

- ☐ Long delivery
- ☐ Difficult delivery
- ☐ Induction
- ☐ Caesarean delivery
- ☐ Forceps/vacuum extraction

APGAR Score? _____

What was the most comfortable position to labor in? _____ deliver in? _____

Congenital anomalies/defects? _____

Name of OB/Midwife/Family MD:_____

Birth location? (circle one) Home Birth Center Hospital

Is your child vaccinated? Y / N

Number of doses of antibiotics taken in past 6 months? _____ lifetime? _____

Is/was your child breastfed? Y / N How long? _____

Sleeping posture? (circle) Side Back Stomach

Difficulty eating/keeping food down? Y / N Special diet/restrictions? _____

Favorite foods frequently eaten? _____

How much does your child consume of the following (please note amount/servings per day/week):

- Pop _____
- Juice _____
- Water _____
- Sweets _____
- Vegetables _____

_____ _____

Parent or Guardian Signature Date