



Dr. Harmony Mir. BMUS, DC
Pediatric Patient Introduction

INFANT HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

CHILDS NAME: _____ Date: _____

MOTHERS NAME: _____ FATHERS NAME: _____

How did you hear about us? _____

Address: _____ City: _____ Prov: _____ PC: _____

Home Tel #: (____) _____ Alt Tel #: (____) _____ Birth date: ____/____/____ Sex: _____
D M Y

MSP#: _____ Email: _____ *office records only

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____ Number of Siblings: _____

Please check the following that apply

Third Trimester Presentation: Vertex Breech Transverse Face/Brow

Type of birth: Normal Vaginal Forceps Cesarean Suction cap/ Vacuum

Location: Home Hospital

Any problems during pregnancy _____

Any problems during labor/ delivery _____

Apgar scores ____ Was Jaundice present at birth (yellow)? ____ Cyanosis (blue)? ____

Congenital anomalies/ defects? ____ if yes, please explain _____

Infant feeding: Breast ____ Bottle ____ if Bottle, which formula? _____

Number of hours sleeping per night ____ Quality of sleep: Good ____ Fair ____ Poor ____

Obstetrician/ Midwife _____ Pediatrician/ Family MD _____

Date of last visit _____ Purpose _____

Immunization History _____

Number of doses of antibiotics your child has taken: During the past six months ____ During his/her lifetime ____

Has your child ever been treated on an emergency basis? Y / N if yes, please explain _____

Purpose of this appointment _____

Can your child do the following:

Please check the following that apply

_____ Respond to sound _____ Follow an object with his/ her eyes _____ Hold head up
_____ Sit alone _____ Crawl _____ Stand _____ Walk alone

Has your child ever suffered from the following childhood diseases:

Please check the following that apply

_____ Chickenpox _____ Mumps _____ Measles _____ Rubella
_____ Rubeola _____ Whooping Cough _____ Other

Has this child ever suffered from:

Please check the following that apply

_____ Headaches _____ Behavioral Problems _____ Poor Appetite _____ ADD/ ADHD
_____ Dizziness _____ Neck Problems _____ Fainting _____ Arm Problems
_____ Stomach Aches _____ Seizures _____ Leg Problems _____ Reflux
_____ Constipation _____ Growing Pains _____ Chronic Earaches _____ Back aches
_____ Diarrhea _____ Sinus Trouble _____ Poor Posture _____ Diabetes
_____ Asthma _____ Scoliosis _____ Allergies To _____ Colds/ Flu
_____ Walking Trouble _____ Colic _____ Broken Bones _____ Bed Wetting
_____ Other

Has this child ever suffered the following spinal traumas?

Please check the following that apply

_____ Baby walker _____ Fall from bed to couch _____ Skateboard or skates
_____ Crib _____ Swing _____ Bicycle
_____ High chair _____ Slide _____ Down stairs
_____ Change table _____ Monkey bars _____ Other

Has this child ever sustained an injury playing organized sports? Y / N

If yes, please explain _____

Has this child ever sustained injuries in an auto accident Y / N

If yes, please explain _____

Surgery _____

Vitamins/Medications _____

Family History _____

Is there any other information that can help us care for your child? _____

I hereby authorize and consent to the chiropractic, evaluation and care of my child.

Parent/ guardian Signature: _____

Witness _____

It is a pleasure to welcome you to Harmony Chiropractic Clinic. We look forward to working towards optimal health and wellness for you and your family!

“Good Health Makes Authentic Living Possible”