**casper chiropractic**
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**Pediatric New Patient Application**
***(Please Print)***

# INFANT HISTORY
## 2 Months to 2 Years

Today's Date: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Age: _____

***The following questions are designed to help the doctor provide the best possible spinal care for the child.***

**NUTRITION**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Is your child still being breast fed? If no, for how long was he/she breast fed? _____ |
| | | If still breast-feeding, how much cow's mild does the mother consume each day?_____ |
| ☐ | ☐ | Is your child formula fed? _____ Which formula or other milk source? _____ |
| ☐ | ☐ | Is your child eating solid food? What foods does his/her diet contain? _____ |
| | | What is your child's favorite food? _____ |
| ☐ | ☐ | Does your child have any feeding difficulties? _____ |
| ☐ | ☐ | Does your child have any digestive disturbances? _____ |
| ☐ | ☐ | Does your child have any food allergies? _____ |
| ☐ | ☐ | Does your child have any persistent or intermittent skin rashes? _____ |
| ☐ | ☐ | Is your child receiving any vitamin supplements? _____ |

**TRAUMA**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | According to the National Safety Council, approximately 50% of infants fall head first form a high place (bed, changing table, stairs, etc.) during their first year of life. Has your child fallen from any height? |
| | | Describe the trauma and the date it occurred. _____ |
| ☐ | ☐ | Has your child ever been in a motor vehicle collision or near-miss? _____ |
| ☐ | ☐ | Has your child ever had a bone fracture or joint dislocation? _____ |
| ☐ | ☐ | Has your child had any other trauma or injuries? _____ |
| ☐ | ☐ | Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____ |
| ☐ | ☐ | Have you noticed any abnormality with the way you child walks or runs? (Ex: limps, high hip, feet turn in or out)? |

**HEALTH HISTORY**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Has your child ever had earaches? |
| ☐ | ☐ | Has your child ever had tubes put in his/her ears? |
| ☐ | ☐ | Has your child ever had colic? |