Life Expressions
Child's History Form

CHILD'S NAME _____PARENTS NAMES_____

ADDRESS_____CITY/TOWN_____ STATE_____ZIP_____

HOME PHONE NUMBER _____WORK PHONE NUMBER_____

BIRTH DATE_____ AGE_____ SEX _____BIRTH WEIGHT:_____CURRENT WEIGHT:_____

LIST NAMES & AGES OF ALL SIBLINGS:_____

_____

WHO MAY WE THANK FOR REFFERING YOU TO THIS OFFICE?_____

TYPE OF BIRTH: NORMAL VAGINAL_____ CESAREAN _____ BREECH _____ FORCEPS_____
SUCTION CAP/VACUUM EXTRACTOR_____HOME ____BIRTHING CENTER ____HOSPITAL____

PROBLEMS DURING PREGNANCY_____over

PROBLEMS DURING LABOR/DELIVERY_____over

LENGTH OF LABOR (TIME)_____

CIRCLE ALL THAT APPLY CONCERNING YOUR LABOR:

POSITION DURING LABOR?:	RECEIVE DRUGS?: YES NO	MONITORING CHILD?: YES NO
ON BACK YES NO	EPIDURAL: YES NO	INTERNAL
SIDE, SITTING, STANDING	MORPHINE: YES NO	EXTERNAL
INDUCED?: YES NO	EPISIOTOMY?: YES NO	

WAS YOUR CHILD SUBJECTED TO?:

DROPS IN EYES: YES NO	INCUBATION: YES NO	HOW LONG:_____	
VITAMIN K: YES NO	SEPARATION FROM YOU: YES NO	HOW LONG:_____	
HIB SHOT: YES NO	HEPATITIS SHOT: YES NO		

CONGENITAL ANOMALIES/DEFECTS_____
INFANT FEEDING BREAST _____ BOTTLE _____ FORMULA_____
NO. OF HOURS SLEEP PER NIGHT _____ QUALITY OF SLEEP GOOD_____ FAIR_____ POOR____
OBSTETRICIAN/ MID WIFE_____
PEDIATRICIAN/ FAMILY MD_____
DATE OF LAST VISIT TO MD_____ PURPOSE_____
VACCINATION HISTORY_____
WHY WERE SHOTS GIVEN?_____
PURPOSE OF THIS APPOINTMENT_____
HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS_____
DESCRIBE_____

AUTHORIZATION FOR CHILD TO RECEIVE CHIROPRACTIC

I HEREBY AUTHORIZE THIS CENTER TO SERVE MY CHILD CHIROPRACTIC

SIGNED_____ WITNESSED_____ DATE_____

I CLEARLY UNDERSTAND AND AGREE that all services rendered to me are charged directly to me and that I am personally responsible for payment. I accept ChiropracTIC based on the above information, my signature below will serve as consent for service.

SIGNATURE_____ DATE_____

PREGNANCY HISTORY:_____

DELIVERY / BIRTH HISTORY: _____

PRESENT HISTORY: :_____

SURGERY:_____

MEDICATIONS:_____

TRAUMA:_____