ADAPT CHIROPRACTIC

Newborn Health Profile

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Contact: Name:_____ Relationship to Child: _____

Number: _____ E-mail:_____

Secondary Contact: Name: _____ Number: _____ Relationship: _____

Pediatrician Office Name: _____

EARLY LIFE SUMMARY

Please circle any of the following that describes your child's typical day:

Being Held In Baby Gear Screen Time In Car Seat Belly Time Back Time Daycare

Please describe your child's typical schedule:

1. Feeding (how often / how much): _____
2. Sleeping/Naps (how often / how long): _____
3. Diapers (How many wet / dirty daily): _____

Does your child have any siblings? ◯No ◯Yes How many?_____

Is your child adopted? ◯No ◯Yes

Has your child had any vaccinations or been on antibiotics in the last 3 months? ◯No ◯Yes Describe:_____

_____

Is/was your child: ◯Breastfed ◯Formula ◯Both

Is your child eating/trying solid food? ◯No ◯Yes

To the best of your knowledge, briefly describe your child's birth story: _____

_____

_____

Has your child ever shown any abnormal head shape or bruising? ◯No ◯Yes Describe _____

_____

Do you notice your child favoring one side of head rotation? ◯No ◯Yes If yes, which side and when do you notice it?

_____

Any abnormalities in your child's walk or crawl? ◯No ◯Yes If yes, describe:_____

_____

Are there concerns for any of the following:

Sleep Digestion Immune Function Balance Ear Infections Development

HISTORY OF CONCERN

Identify and describe your child's chief concerns:

	Health Concerns Listed According to Severity:	When Did This Problem Begin?	When is it at its Worst? (AM, Mid-day, PM)	Are Symptoms Constant or Intermittent?
Primary:	_____	_____	_____	_____
Second:	_____	_____	_____	_____
Third:	_____	_____	_____	_____
Fourth:	_____	_____	_____	_____

What relieves your child's symptoms? _____

What makes your child's symptoms worse? _____

Does your child take any of the following for their symptoms?

◯Gas Drops ◯Antibiotics ◯Aleve ◯Other: _____

How Often?

◯Daily ◯Weekly ◯Monthly

Did any of these concerns occur from (or after) an accident or injury? ◯Yes- What Happened? ◯No

_____

_____

DOES YOUR CHILD APPEAR TO BE IN PAIN?

◯No ◯Yes If yes, please describe:_____

_____

_____

CIRCLE ALL FUNCTIONAL ISSUES THEY HAVE OR HAVE HAD

Trouble Sleeping	Frequent Colds	Chronic Fatigue	Allergies	Anxiety
Heartburn	Dizziness	Balance Issues	Vision Issues	Vertigo
Ear Infections	Ringing in Ears	Hearing Loss	Sinus Issues	Thyroid Issues
Heart Issues	High Blood Pressure	Low Blood Pressure	Lung Issues	Asthma
Liver Disease	Gallbladder Issues	Digestive Issues	Kidney Issues	Bladder Issues
High/Low Pain Tolerance	Bed Wetting	Delayed Development	Skin Issues	Depression
Eating Disorder	Mood Changes	ADD/ADHD	Lupus	Fibromyalgia
Other:_____	_____	_____	_____	_____

ADDITIONAL HEALTH INFORMATION

CIRCLE ANY OF THE FOLLOWING THAT YOUR CHILD HAS OR HAVE HAD:

Stroke Cancer Heart disease Spinal Surgery Seizures Spinal Bone Fractures Arthritis Diabetes

ANY FAMILY HISTORY OF:

Stroke Cancer Heart disease Spinal Surgery Seizures Arthritis Diabetes

DO ANY OF THIS CHILD'S PARENTS SUFFER FROM:

Headaches/Migraines ADD/ADHD Ear Infections Sciatica Digestive Issues Anxiety/Depression

Any other hereditary conditions? ◯No ◯Yes

_____

_____

List all surgical operations and years:

_____

_____

List all prescription medications your child is taking:

_____

_____