JJL Chiropractic – JJL Auriculomédecine - Baby Entrance Form

Baby's name: _____Today's date: _____
Date of birth: _____ Age: _____ Sex: Male Female
Address: _____
Phone: Home: _____
Mobile: _____ Email address: _____
Names of Parents/Guardians:_____
Name of person who referred:_____
Reason for visit to us today : _____
Previous Chiropractor: _____ Date of last visit: _____
Name of Plunket Nurse: _____ Date of last visit: _____
Name of Medical Doctor: _____ Date of last visit: _____

Pre-natal History:

Name of Midwife/Obstetrician: _____
Complications during pregnancy? _ List: _____
Ultrasounds during pregnancy? _ Number: _____
Medications during pregnancy/delivery? _ List: _____
Cigarette/Alcohol use during pregnancy? _

Birth History:

Location of birth: _____
Normal Vaginal _ Forceps _ Vacuum extraction (Ventouse) _ Breech_ Induced _ Caesarean section: _
Complications during delivery? _ List: _____
Genetic disorders or disabilities? _ List: _____
Birth weight: _____ APGAR Scores: _____

Feeding History:

Breast fed: _ How long? _____
Formula fed: _ How long? _____ Type: _____
Has your baby fed well off one breast/side in preference to the other? _____

Developmental History:

At what age was your child able to :
Hold head up _____ Crawl _____ Sit up _____ Stand alone _____ Walk alone _____
According to the US National Safety Council, approximately 50% of babies fall headfirst from a high place during their first year of life (from a bed, changing table, down stairs, etc.). Was this the case with your baby? _
Sometimes the following symptoms may be an indication that your baby has subluxations. Has your baby experienced any of the following?
Colic _ Ear infections _ Seizures _ *Chronic Colds* _ Digestive Problems _
Constipation _ Reflux_ Allergies _ Other _____
Does your baby have any known health conditions? _____
Any antibiotics your baby has taken In the last six months: _____ Total during lifetime: _____
Please list other prescription medications taken: _____
Have you chosen to have your baby vaccinated? _
Has your baby had any surgery? _ List: _____
No. of hours sleep per night _____ Quality of sleep: _____
Does your baby settle well? _
Are there any positions your baby does not like? (E.g. lying on back or stomach)_____
Has your child been diagnosed as having Congenital Hip Dislocation (Clicky Hips)? _
Do you have a preferred appointment time? When? _____

Authorization for care of minor

I hereby authorize this office to administer care to my baby as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.
Name of Parent/Guardian: _____

Signed: Date: _____

*Please insure your mobile is switched off

Return completed form prior to appointment time to: chirolob@yahoo.com

Reset