ARMSTRONG
CHIROPRACTIC CLINIC, LLC

Infant/Child Assessment Form

Date:________________________

Patient Name: ____

Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other, please list:________________________

Type of Birth: ☐ C-section ☐ Vaginal

Was ultrasound used during pregnancy? ☐ Yes ☐ No If yes, how many times:__________________________

Was labor induced? ☐ Yes ☐ No If yes, why:____

____

Was anesthesia used? ☐ Yes ☐ No Type(s) of anesthesia used:_______________________________________

____

Was there any notable Doctor assisted birth trauma? ☐ Twisting or Pulling ☐ Vacuum Extraction ☐ Forceps

☐ Other:____

Were there any special medical procedures or tests performed? ☐ Yes ☐ No If yes, please list:______________

____

Was the child breastfed? ☐ Yes ☐ No If yes, to what age:____

According to the National Safety Council, over 50% of all infants fall from a place 4ft or higher during their first 2 years of life.

Can you recall ANY jolts, falls, or traumas to this child? ☐ Yes ☐ No If yes, please describe:______________

____

Has this child experienced any fractures or dislocations? ☐ Yes ☐ No Please describe:_____________________

____

Other than the time spent sitting in a classroom, does your child spend prolonged time sitting? ☐ Yes ☐ No

Which activities does this child participate in? ☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey

☐ Basketball ☐ Video Games ☐ Dance ☐ Wrestling ☐ Baseball ☐ Softball ☐ Cheerleading

☐ Other: _____________________________________

How would you rate your child's overall diet? ☐ Poor ☐ Somewhat Healthy ☐ Healthy

Please mark any of the following conditions your child has experienced: ☐ Colic ☐ Irregular Sleeping Patterns

☐ Nightmares ☐ Seizures ☐ Tantrums ☐ Ear Infections ☐ Allergies ☐ Asthma ☐ Headaches

☐ Poor Digestion ☐ Repeated Infections or Colds ☐ Bed Wetting ☐ Learning Disorders ☐ Emotional

Disorders ☐ ADD or ADHD ☐ Other____

Please list all medications your child has been treated with since birth:________________________________

____

Were you informed of any adverse reactions to any of the above listed medications? ☐ Yes ☐ No

Authorization

I hereby authorize the Doctors and Staff at Armstrong Chiropractic Clinic to examine and treat my: ☐ Son ☐ Daughter. Having carefully read the attached informed consent, I hereby give my informed consent to have chiropractic treatment administered.

Parent/Legal Guardian Signature: ____________________________________ Date: ___________________