healthy for life
chiropractic bournemouth

Welcome to our office

Our chiropractic mission is to enable you to be the best you can be.

New Client Details Form for Infants (from birth to 6m)

Child's Surname: Age:

Child's Forename(s): DOB:

Parent / Caregiver's Name:

Address:

Home Tel: Work Tel:

Mobile: Email:

No & Age of siblings:

How did you hear about us? (If recommended, by whom?)

Name and Practice of GP

YOUR BODY IS DESIGNED TO BE HEALTHY. If it is not, there is always a cause or reason. Throughout life many events occur that may affect your health.

The following questions will help your Chiropractor assess any layers of dysfunction, particularly to your child's nervous system, that may have adversely affected your child's health.

Please tick and complete where appropriate. All information will be handled in the strictest confidence.

Your Pregnancy

A Mum's health during her pregnancy can have an influence on the health of the baby.

During your pregnancy did you:

O Have back pain O Have pubic pain O Any other pains: _____
O Have high blood pressure O Have diabetes O Have bleeding O Excess vomiting
O Smoke O Drink Alcohol O Drink Caffeine O Take any medication/drugs
O Take folic acid O Take fish oil O Take a pro-biotic O Experience high levels of stress

The Birth

The birth process can be quite traumatic for mother and baby and is often where spinal dysfunction first occurs.

Was the birth:

O Unassisted O Forceps / Suction O Caesarean O Short duration O Premature
O Induced O Breech O Drug assisted O Prolonged labour O Distressed

Birth Weight _____ lbs/kgs Length _____ ins/cm Head Circumference _____ cm

Apgar Score: At 1minute _____/10 At 5 Minutes _____/10

Feeding History

Difficulties with sucking, latching on and positional preference may be indicative of spinal dysfunction.

Is your baby:

O Breast fed For how many weeks/months? _____
O Bottle fed Which formula? _____
O Mixed Proportion? _____

If breast fed does / did your baby latch on and suck evenly on both sides? Yes / No

_____

Does your baby vomit large quantities of their feeds?

_____

How often does your baby fill their nappy? _____
Consistency?_____ Colour? _____

Sleeping History

Does your baby settle easily and sleep well? _____
Hours of unbroken sleep (day) _____
Hours of unbroken sleep (night) _____
Preferred sleeping position? _____
Preferred sleeping location? _____

Crying History

Does your baby cry inconsolably for long periods?

O yes O No

If yes: O Day O Evening O Night

Immunisation History

Has your baby had the routine immunisations?

O yes O No

Did your baby have any adverse reactions?

O yes O No

Details: _____

Health History

Does/has your baby suffer(ed) from:

O Colic	O Mumps	O Ear Infections	O Cough/breathing probs
O Allergies	O Chicken Pox	O Eczema	O Tonsillitis / Throat infection
O Measles	O Bronchiolitis	O Chestiness	O Other_____

Has your baby:

O Had any major accidents	O Had surgery	O Required medication
O Use a baby bouncer	O Use a baby walker	

Current Health

What aspects of your baby's health currently concern you and what has prompted your visit today?

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form.