**Sozo Chiropractic & Wellness, LLC**
**409 W. Wall St**
**Grapevine, TX 76051**
**469-223-8836**
**www.sozochiro.com**

**Child's Name: _____ Date: _____**

DOB: _____ Current Age: _____

**History of Birth**

Child's gestational age at birth? _____ Weeks

Birth weight: _____ lbs _____ oz Birth length: _____ inches

Was your child's birth: At Home In a Birthing Center In a Hospital

Was the birth considered: Medical Midwife and/or Doula

What was the duration of the labor and birth? _____ hours

Was the child born: Cephalic (head first) Breech (feet first)

Were there any complications? No Yes - Explain _____

_____

Please circle any assistance which was used during the birth:

Forceps Vacuum Extraction C-Section Episiotomy

Was labor: Spontaneous Induced

Were medications or epidurals given to the mother during birth? No Yes - Explain

_____

APGAR Score: At Birth _____/10 After 5 minutes _____/10

Was the infant alert and responsive within 12 hours of delivery? Yes No - Explain

_____

Do you consider the child's sleeping pattern normal? Yes No - Explain

_____

***Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.***

**Physical Stressors**

Any traumas to the mother during pregnancy? (Eg. falls, accidents, etc.) No Yes - Explain

_____

Any evidence of birth trauma to the infant?

Bruising Odd Shaped Head Stuck in Birth Canal Respiratory Depression

Fast or Excessively Long Birth Cord Around Neck

Any falls from couches, beds, change tables, stairs, etc? No Yes - Explain

_____

**Chemical Stressors**

Was your child breast-fed? No Yes --- How Long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Began solids what age? _____ Type of foods? _____

Food/Juice intolerance? No Yes - what type? _____

During pregnancy, did the mother: Smoke? No Yes - How much? _____
Drink? No Yes - How much? _____

Any illnesses during the pregnancy? No Yes -- Explain _____

Any supplements taken during pregnancy? No Yes -- which ones?
_____

Any drugs taken during pregnancy? No Yes -- which ones?
_____

Any ultrasounds? No Yes How many and reasons for being done?
_____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? No Yes - Explain
_____

Any pets at home? No Yes - What kind? _____

Any smokers in the home? No Yes

**Vaccination History**

Vaccinations and age given: _____
_____

Any negative reactions? No Yes -- Explain _____
_____

Any antibiotics given? No Yes -- Reason _____
_____

**Psychosocial Stressors**

Any difficulties with lactation? No Yes -- Explain _____
_____

Any problems with bonding? No Yes -- Explain _____

Any behavioral problems? No Yes -- Explain _____
_____

Any: Night Terrors Sleep Walking Difficulty Sleeping Bed Wetting

Do you feel that your child's social and emotional development is normal for their age? Yes No - Explain
_____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

AUTHORIZATION FOR CARE OF A MINOR (UNDER 18 YEARS)

Parents' Names: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____

Parent/Guardian Print Name: _____

Date: _____

FOR CHIROPRACTOR'S USE ONLY

Palpatory Findings:

Tone of Musculature:

Leg Check Analysis:

Listings:

Vertebrae Adjusted:

Additional Information: