Optimal Spine Chiropractic

Discover Your Wellness Potential

Newborn/Pediatric Addendum

Child's Name: _____ Date of Birth: _____

Parent's Names: _____ _____

Address: _____

Phone: _____ email: _____

Pediatrician's Name: _____

Whom may we thank for referring you? _____

Reasons for visit:

☐ Wellness Check

☐ _____

Pregnancy Complications: (Check all that apply)

☐Hip/pelvic/low back pain ☐Upper/mid back/neck pain ☐Numbness ☐Baby Position

Other: _____

For Office Use:

Birth History: (Check all that apply)

☐Home ☐ Hospital/Birth Center ☐vaginal ☐cesarean ☐forceps ☐vacuum ☐induction

Of weeks gestation: _____ Baby's birth weight: _____ Number of prior pregnancies: ____

For Office Use:

Feeding History: (Check all that apply)

☐Breastmilk ☐Formula ☐Both

☐ Current Latch Problems _____

☐ Previous Latch Problems _____

Lip/Tongue Tie:

☐None ☐Suspected ☐ Surgically released date _____ Results: _____

_____

Developmental Concerns: _____

Digestive Concerns: _____

Sleep Concerns: _____

Congenital Anomalies/Defects/Surgeries: _____

Vaccination history: ☐none ☐delaying ☐following CDC schedule ☐questions/undecided

Number of courses of antibiotic treatments since birth: ____ Reasons:_____

Other Medications: _____