Gateway Chiropractic of Ann Arbor, LLC

Diane Babalas, D.C.

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734-239-6060 gatewaybgi@gmail.com

Name of Child_____ Birth Date _____ Age_____

Name of Parents _____

Address:City, State Zip Code_____

Email_____ Phone_____

Siblings, ages_____

How did you hear about our office?_____

Do you have any concerns about your child or is this a wellness visit?_____

Please describe any concerns _____

_____

Pregnancy:

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter? □ Yes □ No
If yes, explain:

_____

Did Mom or Dad smoke during pregnancy? □ Yes □ No Who? _____

Was the baby ever in the Breech position? □ Yes □ No
How many ultrasounds were preformed? _____

Birth & Delivery

Where was the baby born? □ Home □ Hospital □ Birthing Center □ Other: _____

Was the delivery:□Vaginal □C-section □ Were any devices used?: Forceps/ Vacuum

How long was the labor? _____ How long was the delivery? _____

Was oxytocin/pitocin used? □ Yes □ No Was as epidural administered? □ Yes □ No

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Was the child breast fed? □ Yes □ No Any complications? _____

For how long?_____

Infancy:

Was the infant vaccinated? □ Yes □ No Any modifications to the schedule? _____
Any known or suspected reactions?_____

Was there any prolonged use of medicines or an inhaler? □ Yes □ No If yes which? __

Did the infant suffer any traumas such as serious falls or car accidents? □ Yes □ No

Has the infant been under regular chiropractic care? □ Yes □ No

Childhood years:

Did the child have any childhood illnesses? □ Yes □ No Explain: _____

Does the child play youth sports? □ Yes □ No Which sport(s)? _____

Has the child had any surgery? □ Yes □ No Explain: _____

Has the child fallen from a height over 3 ft? □ Yes □ No Explain: _____

Was the child involved in any car accidents? □ Yes □ No Explain: _____

Has there been any prolonged use of meds? □ Yes □ No Explain: _____

Has the child suffered emotional traumas? □ Yes □ No Explain: _____

Is there anything else you would like us to know about your child?:_____

_____

_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature: _____ Date: _____