Please fill in this form at the first consultation and answer it as well as you can. The answers are very important to us in order to give you the best treatment possible. If you are I doubt then skip the question. We will review the form at the consultation.

Baby's name:_____ **Date:**_____

Baby's CPR:_____

Parents' names:_____

Parents' phone numbers:_____

Parents' e-mailsadress:_____

What is the reason for this consultation?

_____

_____

_____

Have you been referred to the clinic? ☐ No ☐ Yes

If yes, by whom?

☐ Health visitor ☐ Kid-physiotherapist ☐ Facebook ☐ Internet

☐ Doctor ☐ Zone therapist ☐ Ergo therapist ☐ Other:_____

Which chiropractor have you been recommended to?

☐ Grethe Thøstesen ☐ Thomas Damsgaard

☐ John Sandsberg ☐ Mathilde Christensen

Pregnancy:

Has there been any complications or inconveniences with you/the mother or the baby during the pregnancy?

☐ No

☐ Yes, which ones?_____

Detalis about the birth can be important information in relations to joint related problems:

Born I week::_____ Weight:_____ Length:_____

Was the birth without comolications?

☐ Yes ☐ No

If no, please put a cross:

☐ Caesarean section ☐ Stargazer

☐ Cupping glass ☐ Other:_____

Was the baby's head uneven the first days after the birth?
☐ Yes ☐ No

Duration of birth/ hours::_____ Pushing fase duration:_____ Number of siblings:_____

The baby's 0th-6th months:
How would you describe your baby's eating habits?: ☐ Good ☐ Fair ☐ Poor ☐ Miserable

How would you despribe your baby's sleep?: ☐ Good ☐ Fair ☐ Poor ☐ Miserable

Stool frequency: _____

Did/ does your baby breastfeed? ☐ No ☐ Yes – How long/ age?_____

How long does breastfeeding take? _____ How long between breastfeedings? _____

Did/ does your baby get breastfed equally from right and left breast? ☐ No ☐ Yes

Did/ do you give your baby formula? ☐ No ☐ Yes – From what age?_____

Does your baby cry? ☐ Yes, a lot ☐ Ja, a little ☐ No

Does the baby follow the normal growth curve? ☐ No ☐ Yes

Are you worried about the shape of your baby's head? ☐ No ☐ Yes

Does your baby follow the Board Of Health's vaccine program? ☐ No ☐ Yes
- If yes. Has there been any reaction to the vaccines? ☐ No ☐ Yes

Currently:
Did/ does your baby tending to bent the neck backwards? ☐ No ☐ Yes
(E.g. when sleeping or carried on the arm)

Did/does your baby have a favorite side? ☐ No ☐ Yes ☐ Right ☐ Left

Did/ does your baby's head tilt to one side? ☐ No ☐ Yes ☐ Right ☐ Left

Did/ does your baby lay in a C-shaped curve? ☐ No ☐ Yes

Other problems (please circle it in):

Constipation	Ear infection	Other:_____
Diarrhea	Asthma	Other:_____
Hyperactivity	Allergies	
Trouble getting/ keeping attention	Poor appetite	Other:_____
	Week immune system	Other:_____

Additional questions:

Has your baby crawled? ☐ No ☐ Yes, at what age?_____

Has your baby walked? ☐ No ☐ Yes, at what age? _____

Has your baby been hospitalized? ☐ No ☐ Yes, at what age and for what for?

_____

Has your baby had any falls/ accidents worth mentioning? ☐ No ☐ Yes

Has your baby been given penicillin? ☐ No ☐ Yes

- if yes, how many times? _____

Has your baby been given prescription medicine? ☐ No ☐ Yes

- if yes, what and/ or what for? _____

Has your baby received other evaluation, examination, treatment or training?

☐ No ☐ Yes, what? _____

Do you have any allergies or other inheritable diseases?

☐ No ☐ Yes, which? _____

Are the other matters you wish the chiropractor to know about the baby and/or your family?

_____

_____

_____

Do you approve to correspondence/ exchange of information with other specialists (usually general practitioner)?

☐ No ☐ Yes

Do you wish to receive newsletter for the Chiropractic guide?

☐ No ☐ Yes – to which e-mail? _____

When the form is complete please return it to the secretary. Thank you.