Spine Arts Center

# Infant Case History

Child's Name: _____ Age: _____ DOB: ___/___/___ Gender: _____

Parent/Guardian: _____ Parent/Guardian: _____

**Prenatal History:** *Please check any of the conditions that occurred during pregnancy:*

| | | | | | |
|---|---|---|---|---|---|
| | Rh incompatibility | | Substance abuse | | Alcohol abuse |
| | CMV | | Lack of oxygen | | Maternal x-rays/illness |
| | Rubella/German measles | | Infections | | Toxemia |
| | Communicable diseases | | Medication | | Venereal disease |

*Describe:*_____
_____
_____
_____
_____
_____

**Birth History:** *Please check any of the conditions that occurred during labor/delivery or hospital stay:*

Age of mother at birth: _____ Length of pregnancy: _____

Child's weight at birth: _____ Birth Hospital: _____

| | | | | | |
|---|---|---|---|---|---|
| | Caesarean | | Lack of oxygen | | Medication give to mother |
| | Medication given to child | | Congenital defects | | Special neonatal care/NICU |
| | Jaundice | | Oxygen administered | | Ventilator |
| | Low APGAR score | | | | |

*Describe:*_____
_____
_____
_____
_____
_____

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**Infant History:** *Please check any of the following conditions that your baby experienced:*

| | | | | | |
|---|---|---|---|---|---|
| | Jaundice | | Antibiotic treatment | | Blood incompatibility |
| | Seizures | | Rubella | | CMV |
| | Toxoplasmosis | | Exposed to drugs/alcohol | | Blood transfusions |
| | Herpes simplex | | Ear infection or fluid | | Breathing difficulties |
| | Meconium stain or aspiration | | Other: | | |

*Describe:*_____
_____
_____
_____
_____
_____

**Hearing History:**

1. Does your baby startle at loud noises? Yes ____ No ____
2. Does your baby quiet to your voice or to music? Yes ____ No ____
3. Does your baby turn toward sounds? Yes ____ No ____
4. Is there a family history of childhood hearing loss? Yes ____ No ____

If YES, please explain:

_____
_____
_____
_____

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| | Condition: | Description: |
|---|---|---|
| | Difficulty sleeping | |
| | Preferred sleeping position | |
| | Feeding difficulties | |
| | Breast feeding | How long: |
| | One-sided breast feeding | Preference: |
| | Formula fed | |
| | Other foods: | |
| | Digestive disturbances | |
| | Food allergies | |
| | Skin rashes | |
| | Vitamin supplements | |
| | Frequent crying | How long: |
| | Intestinal gas | |
| | Preferred head position | |
| | Arching back of head & neck | |
| | Irritable during diaper change | |
| | Fever | |
| | Falls | |
| | Car accident | |
| | Bone fractures or dislocations | |
| | Trauma | |
| | Vaccinations | |
| | Other: | |

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