

Birth History

Child's Name: _____

Parent/Guardian Name: _____

To provide holistic care for all children, we believe it is important to record information regarding each child's birth. Please complete the following as accurately as you recall. Thank you.

PRENATAL INFORMATION

1. Were there any unusual symptoms at any time throughout your pregnancy? If yes, please explain:

2. Did you contract any infectious diseases during the final trimester of your pregnancy? If yes, please explain:

3. Did you use prescriptive medication? If yes, please explain:

Any non prescriptive medication?

Any tobacco, alcohol, etc.?

4. Did you or do you have any consistent medical needs that require monitoring?

5. Did the birth take place on/before/after the expected due date? Please elaborate:

PERINATAL INFORMATION

1. Age of mother at birth:

2. Age of father at birth:

3. Please list any siblings and their birthdays:

4. Name of hospital and location:
5. Length of labor in hours:
6. What type, if any, anesthesia was used?
7. Were x-rays needed, why?
8. Was delivery c-section or vaginal?
9. Describe any other complications, if applicable:

POSTNATAL INFORMATION

1. What was your child's apgar score?
2. Did your child show any distress signals after birth?
3. Did your child experience any difficulties with breathing, feeding or motor ability?
Please explain:
4. Child's weight: length: head circumference:
5. How long was your child hospitalized following birth?
6. Has your child ever been hospitalized for any other reason? If yes, at what age and for what reason?

7. Has your child ever had any of the following conditions? If so, please explain and provide dates if known:

Seizures	hepatitis	hypoglycemia
Mumps	roseola	scarlet fever
Pneumonia	Measles	Whooping Cough
Diabetes	Hemophilia	Strep throat
Asthma	Hyperactivity	Hay fever
Hyperactivity gag reflex	Croup	Rubella
Chicken Pox	Gastro-esophageal reflux	
Congenital heart condition		

8. Is your child susceptible to the following conditions? If so, please circle:

Constipation	Diarrhea	Tonsillitis
Ear infections	Bronchitis	Bladder infections

9. Please list any therapy programs your child has attended since birth. Include where and the name of the program.

10. Does your child have any distinguishing marks (birth marks, moles, scars, etc)? If yes, please describe appearance and location:

11. Are your child's immunizations current? If not, please explain and include a current immunization record.