Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: _____ Date: _____

Parent(s) Name: _____

Sibling(s) Name(s) (Ages): _____

Address: _____ City: _____ Prov. _____

Postal Code: _____ Home Phone: (____) _____ Bus Phone: (____) _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F Referred by: _____

Health Card Number: _____

Has your child ever received chiropractic care? ☐ Yes ☐ No If yes, previous DC's name and last visit date?

_____

Name of Medical Doctor: _____

Date of last MD visit and reason: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____ WORK TEL: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

Present Health Complaints/Concerns:

Please complete as appropriate; if there are no complaints/concerns please go to next page.

Major: _____

_____

Minor: _____

_____

When did this problem begin? _____

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does problem radiate? ☐ Yes ☐ No If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? _____

Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

_____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss Of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss Of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness In Leg(s)
☐ Loss Of Concentration	☐ Shortness Of Breath	☐ Sinus Congestion	☐ Numbness In Feet
☐ Loss Of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness In Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss Of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: _____

History of Birth

What was the child's gestational age at birth? _____ Weeks.

Birth weight _____lbs._____oz._____Birth length _____inches

Was your child's birth ☐ at home ☐ in a birthing center ☐ in a hospital

Was the birth considered ☐ medical ☐ midwife

What was the duration of the labour and birth?_____hours

Was child born ☐ Cephalic (head first) ☐ Breech (feet first)

Were there any complications? ☐ Yes ☐ No If yes, please explain _____

_____

Please check any assistance which was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

Was labour ☐ Spontaneous ☐ Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No If yes, what was given? ____

_____

APGAR score: at Birth _____/10 After 5 minutes _____ /10

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain_____

_____

At what age did the child: Respond to sound _____ Follow an object _____Hold up head _____Vocalize _____

Sit alone _____ Teeth _____Crawl_____Walk _____

Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No If no, please explain_____

_____

Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family _____

Father's family _____

Sibling(s)_____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) ☐ Yes ☐ No If yes, please explain _____

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal

☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

Any falls from couches, beds, change tables, etc? ☐ Yes ☐ No If yes, please explain _____

_____

Any traumas resulting in bruises, cuts, stitches, or fractures? ☐ Yes ☐ No If yes, please explain _____

_____

Any hospitalizations or surgeries? ☐ Yes ☐ No If yes, please explain_____

_____

Any sports played?_____

Is a school backpack used? ☐ Yes ☐ No If yes, is it ☐ Heavy ☐ Light

Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type?_____

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? _____

drink? ☐ Yes ☐ No How much? _____

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? _____

_____

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? _____

_____

Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain___

_____

Any pets at home? ☐Yes ☐No If yes, what kind(s)? _____

Any smokers in the home? ☐Yes ☐No

Vaccination History

Vaccinations and age given? _____

Any negative reactions? ☐Yes ☐No If yes, what were they? _____

Any antibiotics given? ☐Yes ☐No Reason? _____

Psychosocial Stressors

Any difficulties with lactation? ☐Yes ☐No If yes, what are they? _____

Any problems with bonding? ☐Yes ☐No If yes, what are they? _____

Any behavioural problems? ☐Yes ☐No If yes, what are they? _____

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No If yes, how? _____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.