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? _____________________________________________________________________

________________________________________

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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
- Numbness In Hand(s)
- 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__________________________________________

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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?
St. Margaret’s Bay Chiropractic Centre

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.