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 help you.

Child’s Name Date Parent(s) Name(s) Siblings Names (ages) Address City Prov. Postal Code Home Phone ( )

Parents Bus. Phone ( )

Date of Birth Age

Referred by Parents Email

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

Parent/Guardian Signature date Witness Signature

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major Minor When did this problem begin? Is this problem (circle) **occasional frequent constant intermittent**

Does problem radiate? **Yes No** If yes, where? What makes this worse?

What makes this better?

Is this 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 any of the following)

o Headaches

o Dizziness

o Fainting

o Irritability

o Depression

o Loss of balance

o Loss of concentration

o Loss of memory

o Ears buzzing

o Poor coordination

o Vision changes

o Loss of smell

o Loss of taste

o Light sensitivity

o Face flushed o Cold sweats o Bronchitis

o Pneumonia

o Difficulty breathing

o Shortness of breath

o Asthma

o Urinary problems

o Constipation

o Diarrhea

o Weight loss

o Weight gain

o Dental problems

o Fevers

o Heart palpitations

o Chest pressure

o Frequent colds

o Sinus congestion

o Sore throats

o Ear pain/infections

o Allergies

o Heartburn

o Bloating/gas

o Upper back pain

o Neck pain

o Low back pain o Radiating pain o Stiffness

o Reduced mobility

o Numbness in leg(s)

o Numbness in feet

o Numbness in hand(s)

o Weakness

o Muscle cramps

o Sleeping problems

o Other:

HISTORY OF BIRTH

What was child’s gestational age at birth? weeks

Birth weight lbs oz Birth length inches

Was your child’s birth (circle one) at home in a birthing centre in a hospital ? Was the birth considered (circle one) medical midwife ?

What was the duration of the labour and birth? hours

Was child born (circle one) cephalic (head first) breech (feet first) ?

Was there any complications? Yes No If yes, please explain

Please circle any assistance which was used during the birth

Forceps Vacuum extraction C-section Episiotomy

Was labour (circle one) 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 mins /10

FAMILY HEALTH HISTORY

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

Mother’s family Father’s family Siblings

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? (ie. Falls, accidents, etc.) Yes No

Please explain

Any evidence of birth trauma to the infant? (please check)

o Bruising

o Stuck in birth canal

o Respiratory depression

o Odd shaped head

o Fast or excessively long birth

o 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 Is it (circle one) heavy light

CHEMICAL STRESSORS

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

Formula introduced at what age?

Which formula?

Introduction of cow’s milk at what age?

Began solid foods at what age?

Type of foods?

Food/Juice intolerance? Yes No Type?

|  |  |  |
| --- | --- | --- |
| During pregnancy, did the mother | smoke? Yes No | How much? |
|  | drink? Yes No | How much? |

Any illnesses during pregnancy? Yes No

Any supplements taken during pregnancy? Yes No Any drugs taken during pregnancy? Yes No Any ultrasounds? Yes No How many and reasons for being done?

Any invasive procedures during pregnancy (ie. Amniocentesis, CVS, etc.)? Yes No

Please explain

Any pets at home? Yes No

Any smokers in the home? Yes No

Vaccination History Vaccinations and age given

Any negative reactions? Yes No

Any antibiotics given ? Yes No Reason

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? Yes No Any problems with bonding? Yes No Any behavioural problems? Yes No Any night terrors, sleep walking, difficulty sleeping? Yes No Age of child when began day care

Average number of hours of television per week?

Do you feel your child’s social and emotional development is normal for their age? Yes No

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.