

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: _____ Province: _____
Postal Code: _____ Home Phone: _____ Bus Phone: _____
Date of Birth: _____ Age: ____ Gender: M F Referred by: _____
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: _____
Health Card Number: _____

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:

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)

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