

CHILD HISTORY

Please complete the following as completely as possible. Ask the front desk staff for assistance if needed.

Child's Name: _____ Date: _____

Child's Date of Birth: _____ Age: _____ M F Referred by: _____

Parent(s) Name: _____ Home # (____) _____ Work# (____) _____

Address: _____ City _____ Prov. _____ Postal code _____

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

Has your child ever been to a chiropractor? Yes No Who? _____ 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): _____

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"/> 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 / Infection | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Loss Of Smell | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Bloating / Gas | |
| <input type="checkbox"/> 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:* _____

Check assistance 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

Note any health problems (eg. cancer, hereditary conditions, diabetes, heart disease, etc.) 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? Fast Or Excessively Long Birth Bruising
 Odd Shaped Head Stuck In Birth Canal Cord Around Neck Respiratory Depression

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?* _____

At what **age** were these introduced: Formula _____ What formula? _____
Cow's milk _____ Solid Foods _____ Type of foods? _____

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

During pregnancy, did the mother: smoke? Yes No *If yes, how much?* _____

drink? Yes No *If yes, 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.