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Child History Form

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: _____

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:

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? _____

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 the family history:

Name: _____

File #: _____

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 | <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

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? _____

Vaccination History

Vaccinations and age given? _____

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

Any antibiotics given? Yes No Reason? _____

Name: _____

File #: _____

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? _____

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? _____

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 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

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

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