

Child and Pediatric Health 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: _____

Cell Number () _____ Home Phone: () _____ Bus Phone: () _____

Date of Birth: _____ Age: _____ Gender: M F

Who may we thank for referring you? _____

Has your child ever received chiropractic care? Yes No

If your child has no symptoms or complaints, and are here for wellness services, please check (✓) here _____ and skip to "Family Health History"

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? _____

Family Health History

Please note any health issues with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

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"/> Rashes | <input type="checkbox"/> Failure to Thrive | <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"/> Seizures | <input type="checkbox"/> Radiating Pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Torticollis/Head Tilt | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Scoliosis | <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"/> Asthma | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Numbness in Feet |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Trouble crawling/walking | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Numbness in Hand(s) |
| <input type="checkbox"/> Eczema | <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"/> Bed wetting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Night Terrors/Poor Sleep | <input type="checkbox"/> Weight Loss/Gain | <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 _____

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 _____

In this office we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxation**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stressors

Any significant falls or trauma to the mother during pregnancy? Yes No Unsure

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

For the child, were there any falls from couches, beds, change tables, etc? Yes No Unsure

Any hospital visits for concussions, possible fractures or other traumas? Yes No Unsure

Have there been any surgeries? Yes No

If yes, please explain: _____

Is a backpack worn? Yes No If yes, is it heavy or light?

Does your child participate in sports? Yes No _____

Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)

Yes No Unsure

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

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.

Patient's signature: _____ Witness: _____ Date: _____

Guardian's Signature: _____ Witness: _____ Date: _____