Children's Health History

Patient # __________ Date: ____________

Personal Information

Name: ____ Birth date: _____________________

How do they wish to be addressed in the office? _____________________ Male Female __________

Address: ______________________________ City/Province/Postal Code: _______________________

Home Phone: ___________________________ Grade: ________ School: ________________________

Parent 1/Guardian's Name: ____________________________ Best Contact: _______________________

Parent 2/Guardian's Name: _____________________________ Best Contact: _______________________

Email Address for parent(s): ____

Marital Status of Parents: Common-law Married Separated Divorced Widowed Other

Sibling's Names & Ages: ____

Previous Chiropractor: ___________________ Last Visit: _____________ Concern: _________________

Medical Doctor: ______________________ Last Visit: ____________ Concern: _____________________

How did you hear about our office? ____

Reason for seeking care today, other practitioners seen for condition, treatment and results:

Prenatal History

Complications during pregnancy? No Yes, list: ____

Complications during delivery? No Yes, list: ____

Ultrasound during pregnancy? No Yes, when: ____

Medications during pregnancy/delivery? No Yes, list: ____

Any invasive procedures (amniocentesis, CVS)? No Yes, list: ____

Location of birth? Hospital Birthing Centre Home

Birth Intervention? C-section Vacuum extraction Forceps

Birth Assistance? OB/GYN Doula Midwife

Apgar Scores: ______ , _______ Cigarette/Alcohol use during pregnancy? No Yes, trimester: __________

Birth Weight: _____________________________ Birth Length: _________________________________

Developmental History

Your child's spine is most vulnerable to stress and should be checked routinely by a Doctor of Chiropractic at the following developmental milestones. Prevention and early detection of vertebral subluxation (spinal nerve interference) is a great way to keep your children growing and developing optimally. At what month was your child able to:

______	Cross crawl	______	Sit up
______	Respond to sound	______	Stand alone
______	Hold head up	______	Walk alone

Has your child ever been taught how to care for their spine? No Yes, explain: __________________________

Do your child's sleep patterns seem normal to you? Yes No, explain: __________________________________

Please indicate any conditions your child may have had, or currently has:

poor appetite	Rubella	Diarrhea	Paralysis
Fainting	Tuberculosis	Hypertension	Sinus trouble
Colds/Flu	Behavioral problems	Asthma	Persistent cough
Bed wetting	Hyperactivity	Eczema/Rashes	Chicken pox
Backaches	Broken bones	Headaches	Allergies
Neck problems	Heart trouble	Chronic earaches	Mumps
Dizziness	Joint problems	Leg problems	Growing pains
Bronchitis	Epilepsy/seizure	Rheumatic fever	Rubeola
Constipation	Digestive Disorders	Arm Problems	Convulsions

Since the neuro-spinal system is sensitive to many types of stressors, the following information is also very important for us to consider:

Chemical Stressors

Breast-fed? No Yes, how long?: _______________________ Introduced solids at ____________ months

If applicable, formula introduced at age: ___________________ Type of formula used: _________________

Was there introduction of cow's/goat's milk? No Yes, age: ____

Food sensitivities, allergies, intolerances, special considerations: No Yes, list: ________________________

Any pets at home? No Yes, type: ____

Any smokers in home? No Yes, location: Indoor Outdoor Car

Number of courses of antibiotics child has taken: ____

Vaccination history: None Suggested Modified, explain: ____

Vaccine reactions (please circle): high pitched screaming, non-stop crying, fever, rashes, hives, convulsions, seizures, other: ____

Psychosocial Stressors

Any difficulties with lactation? No Yes, explain: ____

Any problems with bonding? No Yes, explain: ____

Any behavioral problems? No Yes, explain: _____________________________ Onset: ______________

Any night terrors or sleep walking? No Yes, explain: ____

Average number of hours of television/day: ____

Traumatic Stressors

According to the National Safety Council, approximately 50% of children will fall from a high place during the first year of life (ie. Bed, change table, down stairs, couch). Was this the case with your child? No Yes
Explain: ____

Is your child involved in any high impact or contact type sports? No Yes, list: ____________________________

Any traumas during pregnancy? (falls, accidents): ____

Any evidence of birth trauma? (bruises, odd shaped head, stuck in birth canal, fast or excessive long birth, respiratory depression, cord around neck, other): ____

Any traumas resulting in stitches, fractures: No Yes, explain: ____

Has your child ever been seen on an emergency basis? No Yes, explain: ________________________________

Prior surgery? No Yes, list: ____

Weight of school backpack: ____

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Guardian's signature: _______________________ Date: ____________________

Thank you for completing this form and trusting us to care for your family.