Date:________________________ Child History Form

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: ____________________________ Home telephone: ____________________________

Address: ____

____ Postal Code: ____________________________

Doctor's Name:____________________________ Doctor's Address: ____________________________

Name of Previous Doctor of Chiropractic: ____________________________

Date of Last Visit (dd/mm/yyyy): ____________________

Child's Height:____________ Child's Weight: ________ Name(s) of

Parent(s) or Guardian(s): ____________________________

Business Telephone: ____________________________

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: ____________________________ ____________________________

Witness: ________________________

What are your chief concerns, if any, with your child's health?

____

____

What is your main reason for contacting us?

____

____

List any other care your child has undergone with regards to this complaint including medication:

____

____

Date of onset (mm/yyyy): __________________

Onset was: (circle one)		
Sudden	Gradual	Associated with an event

Duration of problem or episode: (circle one)				
Minutes	Hours	Days	Months	Years

Pattern of Problem: (circle one)			
Constant	Intermittent	Occasional	Cyclical

Initiating Factors: ____________________________

Aggravating Factors: ____________________________

Relieving Factors: ____________________________

How does the problem affect your child's body function and daily activities?

____

Prior occurrence or episodes? ____________________________

____

History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation:_________weeks

Was the birth assisted? □ Yes □ No If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what?________________________Duration of Birth: ______

Was the delivery normal? □ No □Yes If no, what complications were there at birth? ______________________________

APGAR at Birth ________

Growth and Development APGAR after 5 minutes____Birth Weight Birth Length _

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain: ______________________

At what age did the child: Respond to sound?_______Follow an object? Hold up head? Vocalize? ______

Sit alone?______Teethe?_______Crawl? Walk? Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) ________________

____

The father's side? ____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: ______________________________

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No 3. Take supplements/vitamins? □ Yes □ No

4. Take drugs? □ Yes □ No If yes, what?_____________________Become ill? If so, how? ________

5. Receive ultrasounds? □ Yes □ No If yes, how many?______6. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long?_______weeks months years

At what **age** was: 1a. Formula introduced?______b. Brand?________________2. Cow's milk?_______yrs 3. Solid foods?_______yrs

Did your child receive vaccinations? □Yes □ No If yes, which ones?____________________Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why? ____________________

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much? ________

Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour problems? □ Yes □ No If yes, what? ______________________________

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify: ________________

Did your child go to daycare? □ Yes □ No From what age?_______yrs Average no. of hours of TV/Computer per week?_______hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth □ Respiratory Depression □ Cord around neck □ Other ______________________________

Any falls/accidents during pregnancy? □ Yes □ No Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe: ______________________________

Any hospitalizations? □ Yes □ No Please explain: ______________________________

Does your child play sports? □ Yes □ No Number of hours per week?________Age child began_yrs

Weight of school backpack?________lbs Approx. Hours spent at play per week?_____________