Child's Name: _____ Date:_____ Patient Number:_____

Parent Names: _____ Sibling's Names & Ages:_____

Child's Age: _____ Birth date: _____ (dd/mm/yyyy) Sex: □ M □ F

Address:_____

Home Phone:_____ Other Number:_____

Family doctor's name: _____ Address:_____

Who may we thank for referring you?_____

Has your child ever received chiropractic care? □ Yes □ No

If yes, who is your child's previous Doctor of Chiropractic?:_____

The date of last visit:_____

The reason for the last visit:_____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent tests done (list date beside): □ Bloodwork _____ □ Urine _____ □ X-Rays _____

Other: explain _____

Please tick the purpose for your child's visit:

□ crisis management □ early detection of problems □ prevention □ wellness

□ maximizing normal growth and development □ other:_____

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: _____ Date:_____

Signature:_____ **Witness:**_____

Doctor of Chiropractic:
Address:

Present Health 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? ☐ *Yes* ☐ *No* Eating? ☐ *Yes* ☐ *No* Daily routine? ☐ *Yes* ☐ *No*

Is this becoming worse? ☐ *Yes* ☐ *No*

Often seemingly unrelated symptoms can manifest as other health concerns..
Please tick if your child has had any of the following

☐ headaches	☐ chest pressure	☐ weight loss
☐ dizziness	☐ breast pain	☐ weight gain
☐ irritability	☐ frequent colds	☐ dental problems
☐ fatigue	☐ sinus congestion	☐ fevers
☐ depression	☐ sore throats	☐ heart palpitations
☐ loss of balance	☐ ear pain/infections	☐ numbness in feet
☐ loss of concentration	☐ asthma	☐ numbness in hand(s)
☐ fainting	☐ cold sweats	☐ weakness
☐ ears buzzing	☐ bronchitis	☐ heartburn
☐ poor coordination	☐ pneumonia	☐ muscle cramps
☐ vision changes	☐ difficulty breathing	☐ upper back pain
☐ loss of memory	☐ shortness of breath	☐ neck pain
☐ loss of smell	☐ allergies	☐ low back pain
☐ loss of taste	☐ constipation	☐ radiating pain
☐ light sensitivity	☐ diarrhea	☐ sleeping problems
☐ face flushed	☐ urinary problems	☐ numbness in leg(s)
☐ reduced mobility	☐ bloating/gas	☐ stiffness

☐ Other: _____

Birth History

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 ☐ hospital ☐ other

Was the birth considered: ☐ medical ☐ midwife Duration of birth: _____ hours
Was child born: ☐ cephalic (head first) ☐ breech (feet first)

Were there any complications? ☐ *Yes* ☐ *No* If Yes, please explain _____

Assistances used during delivery: ☐ Forceps ☐ Vacuum extraction ☐ C-section ☐ Episiotomy

Was labour: ☐ spontaneous ☐ induced

Were medications or epidurals given to the mother during birth? ☐ *Yes* ☐ *No*
APGAR score: at Birth _____/10 After 5 minutes___/10

Is there anything else we need to know about the birth ☐ Yes ☐ No

Growth & 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 _____ Teethe _____
Crawl _____ Walk _____

Does your child sleep: ☐ front ☐ back ☐side

Do you consider the child's sleeping pattern normal? ☐ *Yes* ☐ *No* How many hours per day? _____
If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:
Mothers family _____
Fathers family _____
Siblings _____

Physical Stressors

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.

Any traumas to the mother during pregnancy? (ie. 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? _____ Is a school backpack used? ☐ *Yes* ☐ *No* Is it ☐ heavy or ☐ light?

Chemical Stressors

Was this child breast-fed? ☐ *Yes* ☐ *No* If yes, how long: _____
Formula introduced at what age: _____ Which formula? _____
Introduction of cow's milk at what age: _____ Began solid foods at what age: _____
Types of solid foods:_____

Food/Juice intolerance? ☐ *Yes* ☐ *No* Type: _____
Is your child on or have taken any medications? _____
During the mother's pregnancy:

Did the mother smoke? ☐ *Yes* ☐ *No* How much? _____

Drink alcohol? ☐ *Yes* ☐ *No* How much? _____

Any illnesses during the pregnancy? ☐ *Yes* ☐ *No* If yes, describe:_____

Any supplements taken during pregnancy? ☐ *Yes* ☐ *No* If yes, describe:_____

Any drugs taken during pregnancy? ☐ *Yes* ☐ *No* _____

Any ultrasounds? ☐ *Yes* ☐ *No* How many:_____ Reasons for being done:_____
_____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? ☐ *Yes* ☐ *No*
If yes, please explain _____

Any pets at home? ☐ *Yes* ☐ *No* _____

Any smokers in the home? ☐ *Yes* ☐ *No*

Any antibiotics given? ☐ *Yes* ☐ *No* If yes, reason: _____

Is the diet organic? ☐ *Yes* ☐ *No* *Do you use 'green products' in your home for cleaning?* ☐ *Yes* ☐ *No*

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? ☐ *Never* ☐ *On weekends* ☐ *A few times per week* ☐ *Daily* ☐ *Nearly each meal* ☐ *On special occasions*

Psychosocial Stressors

Any difficulties with lactation? ☐ *Yes* ☐ *No* _____

Any problems with bonding? ☐ *Yes* ☐ *No* _____

Any behavioral problems? ☐ *Yes* ☐ *No* _____

Any inattention? ☐ *Yes* ☐ *No* _____

Any hyperactivity or restlessness? ☐ *Yes* ☐ *No* _____

Any compulsiveness? ☐ *Yes* ☐ *No* _____

Any difficulties at daycare or school? ☐ *Yes* ☐ *No* _____

Any challenges with learning deficiencies? ☐ *Yes* ☐ *No* _____

Any night terrors, sleep walking, difficulty sleeping? ☐ *Yes* ☐ *No* _____

Any prolonged temper tantrums or separation anxiety? ☐ *Yes* ☐ *No* _____

Is the child in day care ☐ *Yes* ☐ *No* _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work ☐ *Yes* ☐ *No* _____

Is the child home schooled? ☐ *Yes* ☐ *No* _____by Whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? ☐ *Yes* ☐ *No* How often do they text or use the phone? _____

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 you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

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Get Well and Stay Well.

First name : _____ Last name : _____

Gender : ○ Male ○ Female

Date of birth : _____ / _____ / _____

Email address : _____

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