Pediatric Health Profile

Memorial Drive Chiropractic & Massage #213 5271 Memorial Drive SE, Calgary, AB

Today's Date:_____

First Name:_____ Last Name:_____

Present Medical Doctor and address:_____

Date of last MD visit and reason:_____

Present length/height:_____ Present weight:_____

Date of Birth:_____(year) / _____(month) / _____(day)

Health History

Chief Health Concerns:_____

_____

Reason for contacting us:_____

_____

List other care undergone for this complaint (including medications):_____

_____

Date of onset: _____(yr)/_____(m)/_____(d) Onset was: Sudden / Gradual / Associated with an Event

Duration of problem (episode): minutes / hours / days / months / years

Initiating factors:_____ Aggravating factors:_____

Relieving factors:_____ Prior occurrence or episodes:_____

Effects of problems on body function and daily activities:_____

_____

Other health concerns:_____

_____

History of Birth

Hospital / Birthing Centre / Home / Medical / Midwife Duration of Gestation:_____weeks

Assisted birth: No / Yes If yes: forceps / vacuum extraction / c-section / induced labour

Medications delivered to mother at birth? No / Yes If yes, what?:_____

Duration of birth:_____ Complications at birth: No / Yes If yes, explain:_____

Was delivery normal?: Yes / No:_____

APGAR at birth:_____ After 5 mintues:_____ Birth weight:_____ Birth length:_____

Growth and Development

Was the infant alert and responsive within twelve hours of 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 sleeping patterns seem normal to you: Yes / No Explain:_____

Any health problems (cancer, diabetes, heart disease etc.)_____

On the mother's side of the family?:_____ On the father's?:_____ With Siblings?:_____

Since problems that Chiropractors concern themselves with can be related to may types of stressors, the following is also very important to us:

Chemical Stressors

Was (is) this baby breast-fed?: No / Yes – For how long:_____

Formula introduced at what age?:_____ Type of formula used:_____

Introduction of cow's milk at age:_____ Began solid foods at age:_____ Type:_____

Age & type of commercial baby food introduction:_____

Food / Juice intolerance: No / Yes – Type:_____

During pregnancy did the mother: Smoke? – Yes / No Drink alcohol? – Yes / No

Any illness of the mother during pregnancy?:_____

Any supplements taken during pregnancy?:_____

Any drugs taken during pregnancy?:_____

Any invasive procedures (amniocentesis)?:_____

Any pets at home: No / Yes Any smokers in the home?: No / Yes – How much?_____

Any vaccinations?: No / Yes – Which ones and any reactions_____

Any antibiotics: No / Yes – Explain_____ Total # courses of antibiotics to date_____

Psychosocial Stressors

Any difficulties with lactation?: No / Yes:_____

Any problems with bonding?: No / Yes:_____

Any behavioral problems?: No / Yes – Onset:_____

Any night terrors, sleep walking, difficulty sleeping?: No / Yes – Specify:_____

Age of child when began daycare:_____ Average number of television hours per week:_____

Does your child seem normal for their age?: Yes / No – Explain:_____

Traumatic Stressors

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

Any evidence of birth trauma? – bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other?:_____

Any falls from couches, beds, change tables: No / Yes Any traumas with bruising, cuts, stitches, fractures?: No / Yes

Any hospitalizations?: No / Yes – Explain:_____

Any surgeries or organs removed?:_____

Sports played and age began:_____ Hours per week played:_____

Weight of school backpack:_____ Hours per week at play:_____

Thank you for completing this form. Please write any other questions you have below:

_____

_____

_____

_____

_____

Thank you for choosing our Chiropractic office.
We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system.
We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Authorization for Care of a Minor

Parent(s) Name(s):_____

Address (If different from Child's):_____

Home phone (If different from Child's):_____ Work phone:_____

I hereby authorize and consent to the Doctors of this clinic and their designated representatives to provide necessary Chiropractic Care including Health History Consultations, Treatments, X-rays, and/or other Procedures. I confirm that I am the custodial parent who has the legal authority to consent to the above.

_____ X_____

Print Name Signature

_____ _____

Date Witness