Marketplace Chiropractic

CONFIDENTIAL CHILD HEALTH HISTORY (0-8yrs)

☐ Dr. Salgueiro ☐ Dr. Carreira

Please fill out this form in its entirety. If you need assistance, please ask the receptionist.

Child's name: _____ Today's Date: M/D/Y_____/_____/_____
How would your child like to be addressed in our office? _____
Address: _____ City: _____ Province: ___Postal Code: _____
Home #: (____)_____ Work #:(____)_____ Cell #:(____)_____
Biological Sex: □M □F Date of birth: M/D/Y _____/_____/_____ Age: _____
Hobbies/Activities/Exercise (how often): _____
Who can we thank for referring you to our office? _____

May we contact you at work? □Y □N What is the best way to contact you? □ Home □ Work □ Cell
May we communicate with you via email? □Y □ N e-mail address: _____
Can we leave messages on your answering machine regarding appointment times and dates? □Y □N
Can we leave messages with other parties regarding appointment times and dates? □Y □N
If yes, with whom _____

Emergency Contact Name: _____ Relationship: _____
Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Authorization of Care for a Minor

Mother's name: _____ Father's name: _____
Work Telephone #: (_____)_____ Work Telephone #: (_____)_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.
Parent/Guardian signature: _____ Date: M/D/Y_____/_____/_____
Witness: _____ Date: M/D/Y_____/_____/_____

Reason for Care

Present reason for contacting our clinic:

□ My child has a specific problem and I want help only with this problem.
□ After his/her specific problem has been relieved, I am interested in learning how to prevent it in the future.
□ After his/her specific problem has been relieved, and I have learned how to prevent it, I am interested in learning how to optimize his/her health.
□ My child has no symptoms and feels well. I am interested in strategies to help him/her to continue to feel well, or even better. (please skip the section titled Current Complaint)

Health History

The human body is designed to be healthy. Throughout your child's life, events occur which damage his/her health expression. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in neurostructural dysfunction. This case history will help us to uncover the layers of damage that have occurred.

Patient Name: _____ □Dr. Salgueiro □Dr. Carreira

History of Child's Birth
Location of birth: □ Home □ Birthing Centre □ Hospital
Birth attendant: □ Midwife □ General Practitioner □ Obstetrician □ None
How many weeks pregnant at birth: _____ Birth weight: _____Birth length: _____
Natural Birth: □Y □N If no, specify intervention used: □ forceps □ vacuum extraction
□ forceful extraction □ induced labor □ C-section (planned / emergency)
Medications delivered to mother during birth? □Y □N If yes, specify_____
Duration of birth: _____ Complications at birth: □Y □N If yes, explain _____
Medications delivered to child at birth: □Y □N_____

Growth and Development
Was the infant alert and responsive within twelve hours of delivery? □Y □N Explain_____
At what age did the child: Respond to sound _____ Follow an object_____ Hold head _____
Vocalize _____ Sit Alone _____ Teethe _____ Crawl _____ Walk_____
Do sleeping patterns seem normal to you: □Y □N Explain:_____
Began solid foods at age _____
During pregnancy did the mother: Smoke □Y □N? Drink alcohol □Y □N ? Drink Caffeine □Y □N?

Chemical Stress
□Y □N Was the child breast-fed? How long? _____
□Y □N Was formula introduced? At what age? _____Type of formula used?_____
□Y □N Has cow's milk been introduced? At what age? _____Allergies/reactions _____
□Y □N Food / Juice intolerance or allergy? Type:_____
□Y □N Any special diets (e.g. vegetarian)? Specify _____
□Y □N Any illnesses of the mother during pregnancy? Specify _____
□Y □N Any supplements taken by the mother during pregnancy? Specify _____
□Y □N Any drugs taken by the mother during pregnancy (prescription/ over the counter/ recreational): Specify_____
□Y □N Any exposures to ultrasound? If so, indicate how many and medical reason _____
□Y □N Any invasive procedures (amniocentesis, CVS, etc)? Indicate test & medical reason _____
□Y □N Any antibiotics? Explain _____Total number of times to date: _____
□Y □N Exposure to cigarette smoke? How much? _____ How long?_____
□Y □N Exposure to any other chemicals? Explain?_____
□Y □N Does the child take any supplements? What types? _____
□Y □N Does the child eat junk/prepackaged/frozen meals? How much? _____
□Y □N Does the child drink caffeinated beverages? What?_____ How much? _____
□Y □N Does the child drink water? How much? _____
Type? □ Tap □ Bottled □ Filtered □ Distilled □ Other _____
□Y □N Does the child take any drugs? (Please include prescription, or over the counter) _____

Patient Name: _____ □Dr. Salgueiro □Dr. Carreira

Psychosocial/Emotional Stress

□Y □N Difficulties with lactation? _____
□Y □N Problems with bonding? _____
□Y □N Behavioral problems? _____
□Y □N Night terrors, sleep walking, bed wetting, difficulty sleeping? _____
□Y □N Does the child experience stress in his/her daily life? □ school □ home □ other_____
□Y □N Does the child experience depression, anxiety or nervousness?_____
□Y □N Has the child been abused physically, emotionally, or sexually?_____
□Y □N Has the child had any other emotional trauma (e.g. posttraumatic stress)?_____
□Y □N Does the child watch television? Average number of hours per week? _____

Physical Stress

□Y □N Any traumas to the mother during pregnancy (falls/accidents)?_____
□Y □N Any evidence of birth traumas? Bruises, odd shaped head, stuck in birth canal, excessively fast or long birth, respiratory depression, cord around neck, in utero constraint, other: _____
□Y □N Has the child ever fallen from a significant height? (e.g. bed, change table, tree, monkey bars) _____
□Y □N Has the child ever fallen down stairs or slipped on ice? _____
□Y □N Does the child participate in any sports? Type _____
□Y □N Did/does the child use walkers, jumpers, swings or similar equipment (exersaucer)?_____
□Y □N Any other trauma or physical stress? _____
□Y □N Does the child have restful sleep? How many hours? _____ Age of mattress?_____
Sleeping posture? □ Back □ Stomach □ Side

Number of hours per week spent at play? _____ Weight of school backpack? _____
Hours spent sitting per day (at school, home, etc)? _____

Current Complaint (skip for wellness patients)

Chief health concern: _____
When did it start: M/D/Y _____/_____/_____ Onset was: □ gradual □ sudden □ associated with an event
What do you think is the cause of the problem: _____
What makes it worse:_____
What makes it better: _____
What is the quality of the pain/problem: □ Sharp □ Dull □ Achy □ Boring □ Stabbing □ Burning □ Throbbing □ Tingling □ Other: _____
Does the pain/problem: □ stay in the same place □ move from one area to another _____
How bad is this problem on a scale of 1-10 with 1 being no problem and 10 being the most severe? ___/10
Pattern of the problem:□Constant □Intermittent □Occasional □Cyclical □___time(s) per day/month/year
Has the child ever had this before: _____
Is this problem: □ Getting progressively worse □ Not changing □ Getting better
Does this problem interfere with: □ Sleep □ School/Work □ Daily Routine □ Other _____
Effects of problem on body function and daily activities: _____
Other health concerns: _____

Has the child had previous chiropractic care □Y □N When:_____
Doctor's name: _____ For what reason:_____
Why was care discontinued? _____

Patient Name: _____ □Dr. Salgueiro □Dr. Carreira

Please list your family physician/most recent physician & date of last visit: _____
May we contact this physician regarding your child's care?_____

Have X-rays or other relevant images been taken? □Y □N _____

Other Symptoms/Conditions

Please check all symptoms your child has had, even if it doesn't seem related to his/her reason for care:

□ Headaches
□ Neck pain
□ Asthma
□ Allergies
□ Cancer
□ Diabetes
□ Back pain
□ Numbness/tingling in limbs, where?_____
□ Constipation/diarrhea
□ Dizziness
□ Weight change
□ Vision problems
□ Arthritis
□ Joint pain? _____
□ Other? _____

What activities do these complaints keep your child from enjoying? _____
Past hospitalizations/surgery:_____
Doctors notes: _____
_____

Family History

□ Diabetes
□ Cancer
□ High blood pressure
□ Heart Disease
□ Digestive issues
□ Stroke

Accident Report

□Y □N Has the child been in an accident within the past year? Date: M/D/Y _____/_____/_____
□ auto □ other _____ Briefly explain the accident? _____
□Y □N Did s/he experience symptoms after the accident? _____
□Y □N Did s/he require post-accident hospitalization? Why?_____
Where? _____ When? _____ What was done? _____
□Y □N Has he/she lost days at school? Dates: _____
□Y □N Is insurance involved? _____ Which company?_____
Attorney's name, if any: _____Claim #:_____
□Y □N Has the child been in an accident over a year ago? □ auto □ other
Details of the Accident(s)/Date(s): _____
_____

Under very rare circumstances, the Doctor and Parent/Guardian together may make the decision to take radiographs (x-rays) of the child. I give my consent to have radiographic images taken of my child.

Signature: _____ Date: M/D/Y_____/_____/_____

I certify that all information on this form is accurate to the best of my knowledge.

Signature _____ Date M/D/Y_____/_____/_____