Child History Form

Child's Name: ______________________________ Date of Birth: (D) _____ (M)______ (Y)___________
Parent(s) Name: ______________________________
Address: ______________________ City:____________________ Postal Code: ______________
(H) Tel: __________________ Other contact #: __________________ Gender: ○ Male ○ Female
Siblings (Name/Age):______________________________
Previous Chiropractic Care? ○ Yes ○ No Doctor's Name: __________________ Last visit: ______________
Referred by: __________________ Name of Medical Doctor: ______________________
Date of last MD visit & reason: ______________________________

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16YRS)

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

Parent/Guardian Signature: ______________________________ Date: ____________________
Witness Signature: ______________________________ Date: ____________________

***PRESENT HEALTH COMPLAINTS/CONCERNS*:**
Please check for the reason of today's visit: ○ Spinal check-up ○ Current health concern - ______________________
____
Major: ______________________________
Minor: ______________________________
When did this problem begin? ______________________________
Is this problem: ○ Occasional ○ Frequent ○ Constant ○ Intermittent
Does this problem radiate? ○ Yes ○ No If yes, where? ______________________
What makes it worse? ____________________ What makes it better? ____________________
Is the problem worse during a certain time of the day? ○ Yes ○ No If yes, when? ______________
Have other professionals been seen for this condition? ○ Yes ○ No If yes, results? ______________
Does this interfere with the child's? ○ Sleep ○ Eating ○ Daily Routine

Often seemingly unrelated symptoms can manifest as other health concerns, please check if your child has had any of the following:

○ Headaches	○ Loss of taste	○ Dental problems	○ Leg pains (growing)
○ Dizziness	○ Light sensitivity	○ Fevers	○ Radiating pain
○ Fainting	○ Face flushed	○ Heart palpitations	○ Stiffness
○ Fatigue	○ Cold sweats	○ Chest pressure	○ Reduced mobility
○ Irritability	○ Bronchitis	○ Breast pain	○ Numbness in leg(s)
○ Depression	○ Pneumonia	○ Frequent colds	○ Numbness in feet
○ Loss of balance	○ Difficulty breathing	○ Sinus congestion	○ Numbness in hand(s)
○ Loss of concentration	○ Shortness of breath	○ Sore throats	○ Weakness
○ Loss of memory	○ Asthma	○ Ear pain/infections	○ Muscle cramps
○ Ears buzzing	○ Urinary problems	○ Allergies	○ Sleeping problems
○ Poor coordination	○ Constipation	○ Heartburn	○ Skin problems
○ Vision changes	○ Diarrhea	○ Bloating/ gas	○ Seizures
○ Loss of smell	○ Weight loss	○ Upper back pain	○ Chronic colds
○ Hyperactivity/ADHD	○ Weight gain	○ Lower back pain	○ Tonsillitis
○ Bedwetting	○ Digestive difficulties	○ Neck pain	○ Other ______________

HISTORY OF BIRTH:

What was the child's gestational age at birth? ___________ weeks **Birth weight:** ________lbs. __________ oz. **Length:**__________in

Was your child's birth ○ At home ○ Birthing center ○ Hospital **Delivery by:** ○ Midwife ○ Medical

Duration of labour & birth ___________ hours **Was the child born:** ○ Cephalic (head 1st) ○ Breech (feet 1st)

Was any assistance used during the birth: ○ Forceps ○ Vacuum extraction ○ C-section ○ Episiotomy

Was labour: ○ Spontaneous ○ Induced **APGAR score:** at birth __________/10 after 5 minutes __________/10

Were there any complications? ○ Yes ○ No If yes, please explain ______________________________

____

Were medications or epidurals given to the mother during labour/birth? ○ Yes ○ No If yes, what was given?____________

____

GROWTH & DEVELOPMENT:

At what age did the child: Respond to sound _________ Follow an object __________ Hold up head __________ Sit alone __________

Teeth __________ Crawl __________ Walk __________

Do you consider the child's sleeping pattern normal? ○ Yes ○ No If no, please explain ______________________

____

CHEMICAL STRESSORS:

Was the child breast-fed? ○ Yes ○ No If yes, how long? ___________ **Any difficulties in lactation?** ○ Yes ○ No

Formula introduced at what age? _________________ **Introduction of cow's milk at what age?** _______________

Began solid foods at what age? _________________ **Was the child colic?** ○ Yes ○ No

Food/Juice intolerance/allergies? ○ Yes ○ No If yes, what type?______________________________

____

During pregnancy did the mother: smoke? ○ Yes ○ No If yes, how much? ______________________

drink? ○ Yes ○ No If yes, how much? ______________________

have any illnesses? ○ Yes ○ No If yes, what type?______________________

take supplements? ○ Yes ○ No If yes, what type?______________________

take any drugs? ○ Yes ○ No If yes, what drugs?______________________

have any traumas? ○ Yes ○ No If yes, explain?______________________

PHYSICAL STRESSORS:

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/accidents 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

FAMILY HEALTH HISTORY:

Please note any health problems (eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family______________________________

Father's family ______________________________

Sibling(s) ______________________________

VACCINATION HISTORY:

Vaccinations and age given? ______________________________

____

Any negative reactions? ○ Yes ○ No If yes, explain?____

Any antibiotics given? ○ Yes ○ No If yes, reason?____

Has your child had any of the following: ○ Chicken Pox ○ Rubella ○ Rubeola ○ Scoliosis
○ Mump ○ Whooping Cough ○ Eczema ○ Measles ○ Meningococcal Meningitis

***PSYCHOSOCIAL STRESSORS*:**

Any problems with bonding? ○ Yes ○ No If yes, explain?____

Any behavioural problems? ○ Yes ○ No If yes, explain?____

Any problems with: ○ Night terrors ○ Sleep walking ○ Difficulty sleeping

Do you feel that your child's social and emotional development is normal for their age? ○ Yes ○ No Please explain______________
____

Parent/Guardian Signature______________________________________ **Date:** ____________________

All of the above information is complete to the best of my understanding