ALLISTON CHIROPRACTIC WELLNESS CENTRE

CONFIDENTIAL PATIENT HEALTH HISTORY (CHILD)

Please complete the following as completely as possible.
If you need assistance, please ask the front desk staff and they will be glad to help you.

Child's Name _____ Birth Date _____ Gender _____
Address _____ City/Town _____ Postal Code _____
Phone (Parent Cell) _____ Email (Parent) _____
Name of Parents/Guardian _____
Sibling's Names _____
Emergency Contact _____ Phone _____ Relationship _____
Whom shall we thank for referring you to our office? _____
Reason for consulting our office today _____
Previous Chiropractor's Name & Date of Last Visit _____
Name of Medical Doctor _____
Date of last MD visit and reason _____

HISTORY OF BIRTH

Child's gestational age at birth	_____ weeks	Duration of the labour and birth	_____ hours
Newborn Stats Length	_____ inches	Weight: __lbs __oz	
Child's Birth Place	○ at home	○ in a birthing centre	○ in a hospital
This birth was attended by	○ Midwife	○ Medical Doctor	
This child was born	○ cephalic (head first)	○ breech (feet/bum first)	
Were there any complications at the time of birth? Please explain.			
Assistance used during the birth	○ Episiotomy	○ Forceps	○ Vacuum Extraction ○ C-section
Labour began	○ spontaneous (on its own)	○ induced (method):	
Medications or epidurals given to the mother during birth	○ Yes ○ No	If yes, name of medication	
APGAR Scores (if known)	at Birth ___/10	After 5 minutes ___/10	
Was the infant alert and responsive within 12 hours of delivery?	○ Yes ○ No	If no, please explain.	

GROWTH & DEVELOPMENT - *At what age did the child:*

Respond to Sound		Follow an object		Hold up head	
Vocalize		Sit alone		Teethe	
Crawl		Walk			

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PHYSICAL STRESSORS One More Time, Child's Name: _____

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.)	○ *Yes* ○ *No*	If yes, please explain:
Any evidence of birth trauma to the infant?	○ bruising ○ stuck in birth canal ○ odd shaped head	○ rapid 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?	○ *Yes* ○ *No*	Please list:

PSYCHOSOCIAL STRESSORS

Any night terrors, sleep walking, difficulty sleeping?	○ *Yes* ○ *No*
Do you feel that your child's social and emotional development is normal for their age?	○ *Yes* ○ *No*
Do you consider the child's sleeping pattern normal? If no, please explain.	○ *Yes* ○ *No*

CHEMICAL STRESSORS

Any illnesses during the pregnancy?	○ *Yes* ○ *No*	Any drugs taken during pregnancy?	○ *Yes* ○ *No*
Any ultrasounds?	○ *Yes* ○ *No*	How many? Reasons?	
Any invasive procedures during pregnancy (i.e. amniocentesis, CVS, etc.)?			○ *Yes* ○ *No*

PRESENT HEALTH CONCERNS *(If you are here for wellness care, please check here ___)*

Major:		Minor:	
When Did Any Problems 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 - ○ eating?	○ daily routine?	○ sleep?	
Is this becoming worse?			
Other professionals seen for this condition		Results with that treatment	

PLEASE CIRCLE – The initial assessment may include a physical exam and x-rays or a thermal spinal scan. Do we have consent to perform these diagnostic tests? Yes No Initial _____

_____ _____

Parent/Guardian Signature Date