STRATFORD
Chiropractic
&Wellness
CENTRE

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur
288 Wellington Street Stratford, ON N5A 2L9 | Phone: (519) 273-9200
Email: info@stratfordchiropractic.com | www.stratfordchiropractic.com

Child (0-13yrs) History Form

Please take a few moments to complete this questionnaire for your child. Your answers will help us to determine if we can accept your child's case. If we sincerely believe that your child's condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with this form, please do not hesitate to ask. THANK YOU.

Personal Information

Child's Name____Gender ☐M ☐F Date____________________

Parent/Guardian________________________________Parent/Guardian______________________________

Siblings names & ages____

Date of Birth D______M______Y_________ Age ___________
School and Grade (if applicable) ____

Address ____
City/Prov.____Postal Code ________________
Home Phone ________________________________ Parent Mobile __________________________________
Parent's Business/Employer_________________________________Business Phone_____________________
May we call you at work? ☐ No ☐ Yes

***Parent Email Address** ____

☐ I AGREE to receive doctor and office correspondence (email addresses will not be shared with anyone outside of this office)

Referrals are our highest compliment; please share with us where you heard about our office:

☐ Current patient/a Friend – name:____
☐ Website ☐ Google search ☐ Social Media (FB/IG) ☐Yellow Pages ☐ Online Yellowpages.com
☐ Beacon Phonebook ☐ Family Doctor ____________________________ ☐ Midwife ___________________
☐ Other - please specify_____________________________________

Reason for consulting this office:

☐Wellness ☐Prevention ☐Symptom Relief

Current Health Information

Name of child's Medical Doctor & city____
Date of last physical examination_____________________________

Is the primary reason for your child being here a Wellness Check? (Circle one) Yes No
If No, What is reason you have brought your child to see us? _________________________________
____
When did this problem begin?____
Has this occurred before? ☐ Yes ☐ No Please describe when _____________________________
How often does it happen? ☐ Constant ☐ Daily ☐ Few times per week ☐ Few times per month ☐ Other _______
Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and goes

What aggravates the condition? ____
What relieves the condition? ____

Are there other areas of concern with this child?______________________________________
____
____

Other doctors/therapists seen for these conditions? ☐ No ☐ Yes
Who?________________________When?________

How does this condition affect this child's:

Ability to sleep?____
Ability to eat?____
Behaviour?____
Ability to play?____

Does this child currently take any medications? ☐ No ☐ Yes_____________________________
Does this child currently take any natural supplements ☐ No ☐ Multivitamins ☐ Omega 3 Other_______________
Is this child currently breastfeeding? ☐ Yes ☐ No If yes, how often? ___________________________
In the past, did this child breastfeed? ☐ Yes ☐ No If Yes, for how long? _______________________

What is your personal satisfaction with this child's diet?
☐ Highly satisfied ☐ Satisfied ☐ Dissatisfied ☐Highly dissatisfied Why?_________________________

If older than 6 months, please answer the following:
How often does your child eat vegetables? ☐ Daily ☐Weekly ☐Almost never
How often does your child eat meat or other proteins? ☐ Daily ☐Weekly ☐Almost never
How often does your child eat foods containing healthy fats? (nuts/seeds/avocado/oils/yogourt etc)
☐ Daily ☐Weekly ☐Almost never
How often does your child consume foods with added sugars? (juice, yogourts, kid snacks, candy, chocolate etc)
☐ Daily ☐Weekly ☐Almost never
On average, how often does this child have bowel movements? ______________________________
Does this child have any difficulty associated with bowel movements?___________________________

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur

288 Wellington Street Stratford, ON N5A 2L9 Phone: (519) 273-9200 Fax: (519) 273-9293 Email: info@stratfordchiropractic.com
www.stratfordchiropractic.com

Is this child currently involved with any sports or physical activities ☐ No ☐ Yes ______________________________
____

On average, how much daily physical activity does this child have? ☐ 0-30min ☐30-60min ☐1-2h ☐2-4h ☐over 4h
On average, how much screen time (devices, TV, gaming) does this child have daily?
☐0-2h ☐2-4h ☐4-6h ☐over 6h ____

Please rate the quality of this child's sleep: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Number of sleeping hours at night: __________ Number of napping hours during the day: ___________

Has this child been exposed to second hand smoke? ☐ No ☐ Yes ____
How many times per year, on average, does your child get sick? ____
Do you have any concerns about your child's temperament/behaviour? ☐ No ☐ Yes _________________________
____

Please check if this child has EVER had any of the following:

Musculoskeletal
☐ Low back pain
☐ Pain between shoulders
☐ Neck pain
☐ Headaches
☐ Arm pain
☐ Leg pain
☐ Jaw pain/clicking
☐ Growing pains
☐ Scoliosis

Nervous system
☐ Fainting
☐ Convulsions
☐ ADD/ADHD
☐ Colic

Cardiovascular/Respiratory
☐ Shortness of breath
☐ Irregular heartbeat
☐ Heart problems
☐ Pneumonia
☐ Bronchitis
☐ Asthma

Eyes/Ears/Nose/Throat
☐ Vision problems
☐ Loss of smell
☐ Dental problems
☐ Sore throat
☐ Earache/infection
☐ Hearing loss
☐ Sinus congestion

Gastro-Intestinal
☐ Poor appetite
☐ Excessive thirst
☐ Frequent nausea
☐ Frequent diarrhea
☐ Frequent constipation
☐ Bloating/Gas
☐ Abdominal cramps
☐ Heartburn
☐ Reflux
☐ Bedwetting
☐ Skin Rashes

General
☐ Fatigue
☐ Anxiety
☐ Irritability
☐ Allergies_____________
☐ Poor sleep
☐ Poor balance
☐ Poor concentration
☐ High stress___________
☐ Frequents Fevers
☐ Frequent colds
☐ Difficulty breastfeeding
☐ Emotional Traumas

Does this child suffer from any other health conditions? ____
____

<u>Birth History</u>

Birth weight:____________ Birth length:_____________ Arrival time: ______wks
Position at birth: ☐ Vertex (head down)☐ Breech (bum down)
Other___________________________☐ Posterior (face-up) ☐ Transverse ☐ Face / Brow first
Was labour: ☐ Spontaneous OR ☐ Induced → ☐ Membranes ruptured ☐ Cervical gel ☐ Pitocin ☐ Other
If induced, do you know why? ____

Any Interventions used: ☐ Forceps ☐ Vacuum extraction ☐ Manual pulling by doctor ☐ Epidural ☐ None
Type of Birth: ☐ Vaginal ☐ C-Section Duration of labour: __________________
Location: ☐ Home ☐ Hospital Assisted by: ☐ Midwife_________________ ☐ Doctor

Any complications during/after delivery: ☐ None ☐ Bruising of face/head ☐ Respiratory distress

□ Difficulty breastfeeding □ Other ____

Any problems during pregnancy with this child? □ Fall onto buttocks □ Low back pain □ Gestational diabetes
□ Hypertension □ Car accident □High Stress □ Other ___________________________________

Past Health History

Please describe any previous traumas and years:

□ Motor Vehicle Accidents (even minor ones)_______________ □ Sports injuries_______________
□ Childhood traumas/falls (from beds/tables/down stairs/off swings/bikes etc. _______________________
□ Birth injuries _______________________□ Other: ___________________________________

At what age did this child: Hold up head __________ Sit alone __________Crawl __________
Stand ____________ Walk alone __________

Has this child ever been to a Chiropractor? □ No □ Yes Name/date ___________________________
As a parent, have YOU ever been to a Chiropractor? □ No □ Yes Name/date _______________________
Has this child ever had any other sort of medical and/or alternative treatments? _____________________

Has this child ever had any x-rays taken? □ No □ Yes Of what area(s)?___________________________
Has this child ever been hospitalized or had any surgical operations? □ No □ Yes _____________________
Has this child ever had ear infections? □ No □ Yes How many and when? _________________________
Has this child ever been prescribed antibiotics? □ No □ Yes Approximate dates and reasons: ____________
____
Has this child ever been prescribed any other medications? □ No □ Yes __________________________

Vaccination history

□ I have chosen not to vaccinate this child □ I have not decided yet □ Full schedule suggested by my doctor
Have you chosen any additional vaccines for this child? □ No □ Flu vaccine □ Hep A □HPV □ other _______
Have you chosen to opt out of any vaccines for any reason? _________________________________
Has your child ever had any known side effects to any vaccines? □ No □ Yes
If yes, please give dates, vaccine type and side effects: ___________________________________

Family Health History

Is there a family history of any of the following conditions?:
□ Obesity □ Allergies □ Heart disease □ Arthritis □ Osteoporosis □ Cancer □ Diabetes
□ Other ____

Thank you for your patience and cooperation in completely filling out this form. The details allow us to perform a specific physical examination, and monitor your child's progress through the stages of care. If you have any questions, please feel free to ask.

Consent for Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined by Dr. Mike Chambers, Dr. Tanya Chambers, Dr. Blair Neely and/or Dr. Sarah MacArthur at the Stratford Chiropractic & Wellness Centre. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctors named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a "hands-on" approach so that we can best assess your child's health. The examination may also include a computerized CoreScore scan, as well as necessary x-rays if indicated (rare).

____
Child Name

____________________________ ____________________________ __________
Parent/Guardian Name Parent/Guardian Signature Date

____
Doctor Witness Signature

\\scwcbs\Public Data\forms\new patients\child

288 Wellington Street Stratford, ON N5A 2L9 Phone: (519) 273-9200 Fax: (519) 273-9293 Email: info@stratfordchiropractic.com