Courtyard Chiropractic Health Centre

Child Patient History

416-724-7888 www.courtyardchiro.com

Child's Full Name:		Preferred Name:	
Parent(s)/Guardian:	Birth date: DD / MM / YY	Age:	Sex:
Child lives with:	Siblings & Ages:		
Address:	City:	Postal Code:	
Phone #:	Health Card:		
Child's Cell #:	Referred by:		
Emergency Contact & Relationship:			
School:	Grade:	Emergency#:	
Pediatrician/Family Phys: ☐ No ☐ Yes Name of Doctor:		Tel:	
Address:	City:	Postal Code:	
Date of last visit & reason:	Current medical concern:		
Previous Chiropractor: ☐ No ☐ Yes Name of Chiropractor:		Tel:	
Address:	City:	Postal Code:	
Date of last Visit:	Spinal X-Ray/Imaging History:		
Describe Child's Previous Chiropractic Experience:			

Describe reasons for seeking our care:

☐ Wellness	☐ Pain	☐ Chiropractor/clinic/pamphlet recommended	☐ Injury Rehab	☐ Muscle Tension	☐ Headache
☐ Posture	☐ Stiffness	☐ Spinal Maintenance	☐ Custom Orthotics	☐ Extremity	☐ Sports Performance	☐ Scoliosis

Other Doctor/professional consult, treatment & results:

Conditions & history: Child's current weight: _____ lbs kg Height: _____ in cm

☐ Allergies	☐ Ear infections	☐ Mental/ Emotional Difficulty	☐ Enlarged glands	☐ Digestive problems/colitis	
☐ Asthma	☐ Scoliosis	☐ Bed wetting ☐ Colic	☐ Seizures	☐ Chronic colds	☐ ADHD
☐ Car accident	☐ Recurring fevers	☐ Temper tantrums	☐ Headaches	☐ Back pain	☐ Neck pain
☐ Growing pains	☐ Dislocated joints	☐ Kidney trouble	☐ Sleep Problems	☐ Bone fracture	☐ Hay Fever

Childhood illness & age:

☐ Chicken pox:	☐ Rubella:	☐ Rubeola:	☐ Whooping cough:	☐ Mumps:	☐ Other

Details of conditions, illnesses or historical concerns:

Pregnancy, birth & neonatal history: Physical and chemical stressors that may relate to chiropractic examination & care of the child.

During pregnancy: ☐ Smoking ☐ Alcohol use ☐ Drug use ☐ Illness ☐ Traumas to mother ☐ Supplements
Describe here:

☐ Vaginal birth	☐ Caesarian section	☐ Difficult or very long labour	☐ Forceps used	☐ Vacuum used	☐ Premature
☐ Induced labour	☐ Epidural	☐ Other meds to mother	☐ Cord around neck	☐ Low APGAR	☐ Full term

Neonatal: ☐ Breech/other ☐ Odd shaped head ☐ Shoulder/neck trauma ☐ Respiratory depression ☐ Stuck in canal ☐ Distress
Describe complications (i.e. wks premature) info you remember about child's birth here:

☐ Breastfed:____mo	☐ Formula fed	☐ Early concerns with health	Birth weight:_____ lbs_____ oz Length:_____ in

AUTHORIZATION FOR EXAMINATION AND CARE OF A MINOR (UNDER 16 YEARS)

All questions contained in this questionnaire are strictly confidential and will become part of your child's chiropractic record.
I hereby authorize and consent to the chiropractic evaluation and care of my child. This may include x-rays. Informed consent will also be obtained.

Parent/Guardian signature: _____ Name:_____ Date:_____

Growth & development:

Indicate age: ☐ Follow object: ☐ Hold up head: ☐ Sit up alone: ☐ Teeth: ☐ Crawl: ☐ Stand: ☐ Walk:

☐ Normal sleeping	☐ Smokers at home	☐ Vaccinations /complications	☐ Difficult lactation	☐ Body image issue / eating disorder
☐ Behavioral issues	☐ Night terrors	☐ Hours of TV/wk _____	☐ Bonding issues	☐ Genetic disorders:

Any falls (indicate head-first) from couches, beds, change tables? ☐ No ☐ Yes, explain:

Do you feel that your child's social and emotional development is normal for their age? ☐ No ☐ Yes, comment:

Are there other overall health issues or issues meeting milestones of growth & development since birth? ☐ No ☐ Yes, explain:

Further Systems Review: List any symptoms, health concerns or diagnoses not described elsewhere.

☐ Dizziness	☐ Fainting	☐ Anxiety/Depression	☐ Yeast Infections	☐ Neuralgia/Numbness/Tingling	
☐ Irritability	☐ Inguinal hernia	☐ Chest pain/rapid beats	☐ Ear aches/noises	☐ Loss of balance	☐ Fatigue
☐ Vision changes	☐ Poor memory	☐ Loss of concentration	☐ Poor coordination	☐ Poor appetite	☐ Vomiting
☐ Constipation	☐ Diarrhea	☐ Excessive thirst	☐ Gas/bloating	☐ Bronchitis	☐ Pneumonia
☐ Dry skin/rashes	☐ Urinary problems	☐ Antibiotics: _____ doses	☐ Kidney infection	☐ Weight gain	☐ Weight loss

Describe conditions & list others:

For Older Girls: Is there any chance that you might be pregnant? ☐ No ☐ Yes

☐ Cramps	☐ PMS	☐ Irregular cycle	☐ Painful Cycle	☐ Discharge	☐ Pregnant	☐ Sexual abuse

Concerns about health & previous doctor's advice:

Musculo-Skeletal-Neurological Symptoms:

☐ Wrist/hand R L	☐ Forearm R L	☐ Elbow R L	☐ Upper Arm R L	☐ Shoulder R L	☐ Posture
☐ Ankle/foot R L	☐ Lower leg R L	☐ Knee R L inner outer	☐ Thigh R L	☐ Hip R L	☐ Buttock R L
☐ Lower back R L	☐ Neck R L	☐ Upper back/blades R L	☐ Rib/side chest	☐ Tendonitis	☐ Spasms
☐ Visual disturbance	☐ Jaw pain/TMJ	☐ Numb/tingling legs or feet	☐ Sciatica	☐ Numb/tingling arms or hands	
☐ Swelling	☐ Skin hypersensitive	☐ Tension top of shoulders	☐ Pain/ache/burn	☐ Neurologist/other specialist visit	

Describe previous diagnoses, specialists, locations & symptoms further, if applicable:

Sleep Posture & Habits: Sleep concerns:

☐ Side sleeper	☐ Back sleeper	☐ Front sleeper	☐ Orthopedic pillow	☐ Well rested	☐ Fatigued

Ergonomics, Work & Play:

Hrs/day @ computer/games:	Hours sitting:	Hours standing:	☐ Heavy lifting	☐ Twisting/bending
Hobbies:	Time at homework:	High impact sports ☐ No ☐ Yes, list:		
Hrs/day or week of exercise:	☐ Phone cradled neck	Rate stress: ☐ high ☐ moderate ☐ low		"Self time" ☐ N ☐ Y

Describe stressors or school concerns:

Supplements, Meds, Hospital visits: List any natural supplements, prescribed or OTC medications with length of use and doses.

☐ Herbs/natural supp	☐ Food allergy/issues	☐ Other therapy	☐ Hospitalization	☐ Unconsciousness	☐ Medications
High Quality Multivitamin ☐ No ☐ Yes	Car accident history ☐ No ☐ Yes	Other traumas ☐ No ☐ Yes	Emergency visits ☐ No ☐ Yes	Surgeries prior/coming ☐ No ☐ Yes	Falls ☐ No ☐ Yes

List supplements, meds (and why taken) and history of events:

24 hours notice required to cancel or change appointments.

WE LOOK FORWARD TO SERVING YOU, IN YOUR HEALTH JOURNEY

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