Barrhaven FAMILY CHIROPRACTIC
Experience the NeuroStructural Difference

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Child History Form

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

Child's Name _____ Date _____
Parent(s) Name_____
Siblings Names & Ages _____
Address _____ City _____
Prov. _____ Postal Code _____ Home Phone (_____)_____
Cell Phone (_____)_____ Date of Birth (dd/mm/yyyy)_____
Age_____ Referred by _____

Has your child ever received chiropractic care? ***Yes*** ***No***
If yes, previous DC's name and last visit date?_____
Name of Medical Doctor _____
Date of last MD visit and reason _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

I hereby authorize and consent to the chiropractic evaluation of my child.

PARENT(S) NAMES _____ PHONE _____

PARENT/GUARDIAN SIGNATURE_____ DATE _____

WITNESS SIGNATURE _____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major_____
Minor_____
When did this problem begin?_____
Is this problem (circle) ***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 sleep?____ eating?____ daily routine?____
Is this becoming worse? _____
Other professionals seen for this condition? _____
Results with that treatment? _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS:
(please tick if your child has had any of the following)

__ headaches
__ dizziness
__ fainting
__ fatigue
__ irritability
__ depression
__ loss of balance
__ loss of concentration
__ loss of memory
__ ears buzzing
__ poor coordination
__ vision changes
__ loss of smell
__ loss of taste
__ light sensitivity
__ face flushed
__ cold sweats
__ bronchitis
__ pneumonia
__ difficulty breathing
__ shortness of breath
__ asthma
__ urinary problems
__ constipation
__ diarrhea
__ weight loss
__ weight gain
__ dental problems
__ fevers
__ heart palpitations
__ chest pressure
__ breast pain
__ frequent colds
__ sinus congestion
__ sore throats
__ ear pain/infections
__ allergies
__ heartburn
__ bloating/gas
__ upper back pain
__ neck pain
__ low back pain
__ radiating pain
__ stiffness
__ reduced mobility
__ numbness in leg(s)
__ numbness in feet
__ numbness in hand(s)
__ weakness
__ muscle cramps
__ sleeping problems

__ other: please specify: _____

HISTORY OF BIRTH

What was the child's gestational age at birth? _____ weeks.
Birth weight _____lbs _____oz Birth length _____ inches
Was your child's birth (circle one): **at home** or **in a birthing center** or **in a hospital**
Was the birth considered (circle one): **medical** or **midwife**
What was the duration of the labour and birth? _____ hours
Was child born (circle one): **cephalic (head first)** or **breech (feet first)**
Were there any complications? ***Yes*** ***No***
If Yes, please explain: _____
Please circle any assistance which was used during the birth:
Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***
Was labour (circle one): **spontaneous** or ***induced***?
Were medications or epidurals given to the mother during birth? ***Yes*** ***No***
If yes, what was given _____
APGAR score: at Birth _____/10 After 5 minutes_____/10

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? **Yes** **No**
If no, please explain _____
At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____
Do you consider the child's sleeping pattern normal? **Yes** **No**
If no, please explain _____

FAMILY HEALTH HISTORY

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mother's family _____
Father's family _____
Siblings _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) **Yes No**
If yes, please explain _____
Any evidence of birth trauma to the infant? (please check)

__ ***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 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** Is it **heavy** or **light**? (circle one)

CHEMICAL STRESSORS

Was this child breast-fed? **Yes No** If yes, how long? _____
Formula introduced at what age? _____ Which formula? _____
Introduction of cow's milk at what age? _____
Began solid foods at what age? _____ Type of foods? _____
Food/Juice intolerance? **Yes No** Type? _____

During pregnancy, did the mother smoke? **Yes No** How much? _____
drink? **Yes No** How much? _____
Any illnesses during pregnancy? **Yes No**
If yes, please specify: _____
Any supplements taken during pregnancy? **Yes No**
If yes, please specify: _____
Any drugs taken during pregnancy? **Yes No**
If yes, please specify: _____
Any ultrasounds? **Yes No** How many and reasons for being done? _____
_____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? **Yes** **No**
Please explain _____
Any pets at home? **Yes** **No** If yes, please specify: _____
Any smokers in the home? **Yes** **No**
Vaccination history Vaccinations and age given? _____
_____
Any negative reactions? **Yes** **No** If yes, please specify: _____
Any antibiotics given? **Yes** **No** If yes, please specify which ones and reasons:
_____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? **Yes** **No** If yes, please specify: _____
Any problems with bonding? **Yes** **No** If yes, please specify: _____
Any behavioural problems? **Yes** **No** If yes, please specify: _____
Any night terrors, sleep walking, difficulty sleeping? **Yes** **No**
If yes, please specify: _____
Age of child when began daycare? _____
Average number of hours of television per week? _____
Do you feel that your child's social and emotional development is normal for their age? **Yes** **No**
_____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

_____
_____
_____
_____
_____
_____
_____
_____
_____