KINSTRUCT HEALTH

CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Welcome to our office. Please fill out the following form to the best of your ability to help the Doctor provide you and your family with the best care possible. If you have any questions, or need help filling out the form please let us know.

PERSONAL INFORMATION

Child's Name: _____ Gender: M F Date of Birth: _____ Age: ____
Parents Name(s): _____ Number of siblings: _____
Address: _____
City *Province* *Postal Code*
Home Phone: _____ Work: _____ Cell: _____
E-Mail: _____ *Is it okay to use your email to send reminders/office information?*
□ *Yes* □ *No*

Have you or your child ever received chiropractic care before? □ Yes □ No
Were you pleased with the care you received? □ Yes □ No
How did you hear about our office? _____
What is the goal of your visit? □ Health maintenance/optimization □ Health problem □ Both

Is your child receiving care from other health care professionals? □ Yes □ No
If so, please name them and their specialty: _____
Who is your family's primary care physician? _____
Address: _____ Phone: _____

*Please list any **drugs** or **medications** your child is taking:
_____
*Please list any **vitamins/supplements/homeopathics**/other your child is taking?
_____
*Please list any **allergies** or **sensitivities** your child has? _____

HEALTH INFORMATION

What health condition brings your child to our office?_____
When did the signs or symptoms first appear? _____
How did the problem start? □ Suddenly □ Gradually □ Post-injury
Is this condition □ Getting worse □ improving □ intermittent □ Constant □ not sure
What makes the problem *better*? _____
What makes the problem *worse*? _____
Has your child ever had a similar condition? □ Yes □ No Please explain; _____
Has your child ever been treated for this problem before? □ Yes □ No

Does your child eat well? □ Yes □ No Have regular bowel/bladder movements? □ Yes □ No
Has your child been in a **motor vehicle accident**? □ Yes □ No
If yes, please explain (and provide year); _____
Does your child play any **sports**? □ Yes □ No which ones? _____
Please list any **surgeries/hospitalizations** including the year:
_____
Please list any **injuries, accidents, falls or fractures** including the year:
_____

Often seemingly unrelated symptoms can manifest as other health concerns. Check off those that apply.

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

PREGNANCY/BIRTH HISTORY

Did mother smoke during the pregnancy? □ Yes □ No Drink alcohol? □ Yes □ No

On a scale of 1 to 5, how **stressful** was the pregnancy for the mother? ____/5

Did the mother have any illnesses or immune issues during the pregnancy? □ Yes □ No

If yes, please explain (include use of antibiotics, medications or interventions):

_____

List any drugs/medications (including over the counter and vaccines) taken <u>during pregnancy</u>?

_____

List any supplements taken <u>during pregnancy</u> (including brand)?

_____

Was your child exposed to ultrasound during pregnancy? □ Yes □ No How many? ____

What were the medical reasons for the ultrasounds (if given)? _____

What position was your child in during birth? Cephalic (head first) Breech (feet first) Posterior

Child's birth was □ at home □ at a birthing center □ at the hospital

Did you go with a □ Midwife □ Obstetrician □ Family Physician

What was the name of your health care provider? _____

Child's birth was □ Natural vaginal without intervention/manual extraction/pain medication

□ Vaginal with interventions

□ Induction or Pitocin □ Pain medication □ Epidural □ Episiotomy

□ Vacuum extraction □ Forceps □ Manual extraction

□ Other: _____

□ C-section

□ Scheduled □ Emergency

Please list reasons for any interventions/complications:

_____

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

Child's birth weight: ____pounds Child's birth length ___ inches APGAR score: ___/10

GROWTH & DEVELOPMENT

What was your child's gestational age at birth: _____ weeks
At what age did your child;
Respond to sound ____ Follow an object____ Hold head up ____ Vocalize ____
Sit alone ____ Teeth ____ Crawl ____ Walk ____

Is/was your child **breastfed**? □ Yes □ No If yes, for how long? _____
Is/was your child **formula fed**? □ Yes □ No What type? _____ What age? _____
At what age was your child introduced to cow's milk? ____ Solid foods at age? _____
Please list any food or juice intolerances? _____
Is your child's diet organic? □ Yes □ No
Do you have any pets at home? □ Yes □ No
Do you have anyone that smokes at home? □ Yes □ No
Has your child received any **vaccinations**? □ Yes □ No □ Delayed schedule Any reactions? _____
Has your child received any **antibiotics**? □ Yes □ No How many times? _____
What was/were the reason(s) for the antibiotics? _____
Does your child get a "cold" often (or flu-like symptoms)? □ Yes □ No How many times a year?_____

Any difficulty with breastfeeding? □ Yes □ No
If yes, please explain; _____
Any difficulty with bonding? □ Yes □ No
If yes, please explain; _____
Any behavioral problems or concerns? □ Yes □ No Please explain; _____
Any night terrors, sleepwalking or difficulty sleeping? □ Yes □ No Please explain; _____
How many hours of **sleep** does your child get per night? ____
At what age did they sleep through the night (5 hours)? ____
How does your child sleep? Stomach Back Side
At what age did your child begin daycare? _____
How many hours of TV does your child watch per week?_____

Are you concern at all with your **child's development** thus far? □ Yes □ No
If yes, please explain; _____

FAMILY HISTORY

Does your family have any of the following conditions?
□ Heart Disease □ Cancer □ Diabetes □ Depression
□ Back problems □ Liver disease □ High blood pressure □ High cholesterol
□ Lung problems □ Scoliosis □ Neck problems □ Osteoporosis
□ Seizures □ Rheumatoid Arthritis □ Other: _____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive further evaluation, and chiropractic care.

Signed _____ Date: _____Witnessed _____