Complete Family Chiropractic & Wellness Centre – Dr. Guillet, Dr. Hewitt428 Westmount Avenue, Unit 1ASudbury, Ontario P3A 5V8 (705) 525-1221

**Pediatric Health History** 

Patient No.

## DEDSONAL HEALTH HISTORY

How would you describe the child's eating habits?

How many wet diapers does the child have per day? \_

DD/MW/YYYY         Age:	PERSONAL HEALTH HISTORY			
□PFarents/Guardians         Name:	Name:		Ace.	Gender: □M
Name:       City:         Province:       Postal Code:       Home Phone:         Prent's Work Phone:       Parent's Work Phone:       Parent's Work Phone:         Prent's Call Phone:       Stblings:       Rearent's Call Phone:         Privician's Name:       Stblings:       Stblings:         Referred To This Office By:	□FParents/Guardians		Aye	
Address:				
Province:       Postal Code:       Home Phone:         Parent's Work Phone:       Parent's Cell Phone:         Physician's Name;       Extended Health Coverage:       Vs         Privation's Name;       Siblings:         Referred To This Office By:	Address:	City:		
Physician's Name:	Province: Postal Code:	Home Phone:		
Physician's Name:	Parent's Work Phone:	Parent's Cell P	hone:	
Referred To This Office By:         NATURE OF THIS VISIT         Wellness Checkup         Symptoms/Complaint:         Other doctors seen for this condition: :: No :: Yes: Who?         Type of Treatment:         Results         What agarevates the child's condition?         What agarevates the child's condition?         What relieves the child's condition?         What gravevates the child is currently taking:	Physician's Name:	Extended Health Co	verage: 🛛 Y	es 🗆 No 🗆 Not sure
NATURE OF THIS VISIT         Wellness Checkup         Symptoms/Complaint:         Other doctors seen for this condition: Do Yes: Who?         Ype of Treatment:         Results         What aggravates the child's condition?         Has this condition occurred before?         No Yes:         What aggravates the child's condition?         Has this condition occurred before?         Is it getting:         Work         Is it getting:         Work         Previous Chiropractic treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractic treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractic treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractic treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractic treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractor treatment:         None         Chiropractor's name and date of last visit:         Previous Chiropractore treatment: <td< td=""><td>Email address:</td><td> Siblings:</td><td></td><td></td></td<>	Email address:	Siblings:		
Wellness Checkup         Symptoms/Complaint:         Cher doctors seen for this condition:       No       Yes:       Who?         Type of Treatment:       Results	Referred To This Office By:	·····		
□ Symptoms/Complaint:	NATURE OF THIS VISIT			
Other doctors seen for this condition:       No       Yes:       Who?         Type of Treatment:       Results       Results         When did this condition begin?       Has this condition occurred before?       No       Yes,         What relieves the child's condition?       Is it getting:       Worse       Constant       Comes/Goes       Better         List any medications the child is currently taking:	□ Symptoms/Complaint:			
Type of Treatment:	Other doctors seen for this condition:  No  Yes:	Who?		
What aggravates the child's condition?   What relieves the child's condition?   Is it getting:   Worse   Constant   Comes/Goes   Better      Previous Chiropractic treatment:   None   Chiropractor's name and date of last visit:   PRENATAL HISTORY Who did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Labor:   How long was the:   1. first stage (dilation to 10cm)?   2. second stage (pushing)?   Labor:   Location of Birth:   Home   Ordershift:   Owage   Delivery Method:   Vaginal   Planned C-Section   Emergency C-Section   What medications used for pain control?   No   Ves, How?   Or of presentation?   Preze of presentation?   Planeed (anterior or posterior) <td>Type of Treatment:</td> <td>Results</td> <td></td> <td></td>	Type of Treatment:	Results		
What aggravates the child's condition?   What relieves the child's condition?   Is it getting:   Worse   Constant   Comes/Goes   Better      Previous Chiropractic treatment:   None   Chiropractor's name and date of last visit:   PRENATAL HISTORY Who did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Wre did the mother see for prenatal care?   Midwife   Obstetrician   Other:   Labor:   How long was the:   1. first stage (dilation to 10cm)?   2. second stage (pushing)?   Labor:   Location of Birth:   Home   Ordershift:   Owage   Delivery Method:   Vaginal   Planned C-Section   Emergency C-Section   What medications used for pain control?   No   Ves, How?   Or of presentation?   Preze of presentation?   Planeed (anterior or posterior) <td>When did this condition begin?</td> <td> Has this condition occurr</td> <td>ed before? <math>\Box</math></td> <td>No □Yes,</td>	When did this condition begin?	Has this condition occurr	ed before? $\Box$	No □Yes,
Is it getting:				
List any medications the child is currently taking:				
Previous Chiropractic treatment:       None       Chiropractor's name and date of last visit:		Comes/Goes		
PRENATAL HISTORY         Who did the mother see for prenatal care?       Midwife       Obstetrician       Other:         Were there any problems during the pregnancy?       No       Yes,	List any medications the child is currently taking:			
PRENATAL HISTORY         Who did the mother see for prenatal care?       Midwife       Obstetrician       Other:         Were there any problems during the pregnancy?       No       Yes,	Previous Chiropractic treatment:	conractor's name and date of la	ast visit	
Labor: How long was the: 1. first stage (dilation to 10cm)? 2. second stage (pushing)?         Location of Birth: Home       Hospital       Other:         Delivery Method:       Vaginal       Planned C-Section       Emergency C-Section         Who delivered the baby?       Midwife       Obstetrician       Other:         Was the birth assisted:       No       Yes, How?       Induction       Forceps       Vacuum extraction         Were any medications used for pain control?       INO       Yes, What medications?       Epidural       Other:	Who did the mother see for prenatal care? $\Box$ Midwife			
Location of Birth: Home       Hospital       Other:	BIRTH HISTORY			
Location of Birth: Home       Hospital       Other:	Labor: How long was the: 1 first stage (dilation to 10g	m)? 2 seco	nd stage (push	ing)?
Delivery Method:       Vaginal       Planned C-Section       Emergency C-Section         Who delivered the baby?       Midwife       Obstetrician       Other:	Location of Birth: Home Hospital Other:			
Who delivered the baby? Midwife Obstetrician Other:   Was the birth assisted: No Yes, How? Induction Forceps Vacuum extraction   Were any medications used for pain control? No Yes, What medications? Epidural Other:   Type of presentation? Head (anterior or posterior) Face Breech   What was the APGAR score? 10 9 8 7 6 or under   Birth Weight: Birth Height:	Delivery Method:  Vaginal  Planned C-Section	Emergency C-Section		
Were any medications used for pain control? No Yes, What medications? Epidural Other:   Type of presentation? Head (anterior or posterior) Face Breech   What was the APGAR score? 10 9 8 7 6 or under   Birth Weight: Birth Height: Birth Height: FeeDING & ELIMINATION HISTORY   For the child not consuming solid foods yet: How is the child feeding: Breast Fed Bottle Fed How Often? For the child consuming solid foods: At what age were solid foods introduced? Does the child: Des the child: Breast Feed Bottle Feed Bottle Feed If the child was breast fed, how long did he/she do so?	Who delivered the baby?	an 🗆 Other:		
Type of presentation? Head (anterior or posterior) Face Breech   What was the APGAR score? 10 9 8 7 6 or under   Birth Weight: Birth Height: Birth Height: Birth Height:   FeeDING & ELIMINATION HISTORY For the child not consuming solid foods yet: How is the child feeding: Breast Fed Bottle Fed How Often? For the child consuming solid foods: At what age were solid foods introduced? Does the child: Breast Feed Bottle Feed If the child was breast fed, how long did he/she do so?				
What was the APGAR score? 10 9 8 7 6 or under   Birth Weight: Birth Height:   FEEDING & ELIMINATION HISTORY For the child not consuming solid foods yet: How is the child feeding: Breast Fed Bottle Fed How Often? For the child consuming solid foods: At what age were solid foods introduced? Does the child: Breast Feed Bottle Feed If the child was breast fed, how long did he/she do so?				er:
Birth Weight:          FEEDING & ELIMINATION HISTORY         For the child not consuming solid foods yet:         How is the child feeding:       □ Breast Fed         □ Bottle Fed       How Often?         For the child consuming solid foods:       □ Does the child:         At what age were solid foods introduced?          Does the child:       □ Bottle Feed         If the child was breast fed, how long did he/she do so?			ו	
FEEDING & ELIMINATION HISTORY         For the child not consuming solid foods yet:         How is the child feeding:       □ Breast Fed       □ Bottle Fed         For the child consuming solid foods:         At what age were solid foods introduced?          Does the child:       □ Breast Feed       □ Bottle Feed         If the child was breast fed, how long did he/she do so?				
For the child not consuming solid foods yet:         How is the child feeding:       □ Breast Fed       □ Bottle Fed       How Often?         For the child consuming solid foods:       □ At what age were solid foods introduced?       □ Does the child:       □ Breast Feed       □ Bottle Feed         If the child was breast fed, how long did he/she do so?       □       □       □       □				
How is the child feeding:       □ Breast Fed       □ Bottle Fed       How Often?         For the child consuming solid foods:       At what age were solid foods introduced?        Does the child:       □ Breast Feed       □ Bottle Feed         If the child was breast fed, how long did he/she do so?	FEEDING & ELIMINATION HISTORY			
For the child consuming solid foods:         At what age were solid foods introduced?         If the child was breast fed, how long did he/she do so?				
At what age were solid foods introduced? Does the child: Des		Fed How Often?		
If the child was breast fed, how long did he/she do so?	For the child consuming solid foods:	Doog the shild Dree		Rottle Food

Poor

🗆 Good

□ Excellent

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428 Westmount Avenue, Unit 1A Sudbury, Ontario P3A 5V8 (705) 525-1221 How many soiled diapers does the child have per day?		
SLEEPING PATTERNS & POSITIONS         What position does the baby sleep in?       Back       Side       Front/Stomach         Are there any sleeping problems?       No       Yes:		
CRYING PATTERNS		
Does the child experience excessive crying? Do Des the child experience excessive crying? No Pes If Yes, what is the: Number of hours/day Number of days/week Number of we Has the child cried constantly for more than 2 hours? Yes No Does the child appear too weak to cry? Pes No	eeks	
IMMUNIZATIONS		
Is the child vaccinated?  No  Yes Are there any visible reactions?		
FAMILY HEALTH HISTORY         Are there any conditions/diseases that run in your family?       DNo       DYes,		

Is there asthma or allergies in the family?	] Yes
Are there any pets in the home? $\Box$ No $\Box$	Yes,
Are there any smokers in the home? $\Box$ No $\Box$ Yes	J

## HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING

□Accidents/Falls	When?	_ Treatment?
□Allergies	When?	_ Treatment?
□Asthma	When?	_ Treatment?
□Colds	When?	_ Treatment?
Constipation	When?	_ Treatment?
Diarrhea	When?	_ Treatment?
□Ear Infections	When?	_ Treatment?
□Fevers	When?	_ Treatment?
□Flu	When?	_ Treatment?
□Headaches	When?	_ Treatment?
□Leg (growing) pains	When?	_ Treatment?
□Meningitis	When?	_ Treatment?
□Surgery	When?	_ Treatment?
□Other	When?	_ Treatment?

## **MILESTONES**

At what age did th	ne child:		
First held head up	)	Sitting up	
Crawling		Standing up	
Walking _		Talking	
Toilet Trained:		-	
(Day/Night) _	/	-	