Complete Family Chiropractic & Wellness Centre – Dr. Guillet, Dr. Hewitt

Date

428 Westmount Avenue, Unit 1A Sudbury, Ontario P3A 5V8 (705) 525-1221

Patient No.

Pediatric Health History

PERSONAL HEALTH HISTORY

DD/MM/YYYY

Name: _____ Birthdate: _____ Age: _____ Gender: ☐M ☐FParents/Guardians

Name:_____

Address: _____City:_____

Province: _____ Postal Code: _____ Home Phone: _____

Parent's Work Phone: _____ Parent's Cell Phone: _____

Physician's Name: _____ Extended Health Coverage: ☐ Yes ☐ No ☐ Not sure

Email address: _____ Siblings: _____

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_____

When did this condition begin? _____ Has this condition occurred before? ☐No ☐Yes, _____

What aggravates the child's condition?_____

What relieves the child's condition? _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐Better

List any medications the child is currently taking: _____

_____

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: _____

Were there any problems during the pregnancy? ☐No ☐Yes, _____

_____

BIRTH HISTORY

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? ☐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:_____

FEEDING & ELIMINATION HISTORY

For the child <u>not</u> 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? _____

Is feeding a pleasant experience for mother and baby? ☐Yes ☐No

How would you describe the child's eating habits? ☐ Poor ☐ Good ☐ Excellent

How many wet diapers does the child have per day? _____

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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: _____
How many hours does the baby sleep during the night? _____

CRYING PATTERNS

Does the child experience excessive crying? ☐No ☐Yes
If Yes, what is the: Number of hours/day _____ Number of days/week _____ Number of weeks _____
Has the child cried constantly for more than 2 hours? ☐Yes ☐No
Does the child appear too weak to cry? ☐Yes ☐No

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? ☐No ☐Yes, _____
_____
Is there asthma or allergies in the family? ☐No ☐ Yes ☐Whom? _____

Are there any pets in the home? ☐No ☐Yes, _____
Are there any smokers in the home? ☐No ☐Yes, _____

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 the child:

First held head up	_____	Sitting up	_____
Crawling	_____	Standing up	_____
Walking	_____	Talking	_____

Toilet Trained:
(Day/Night) _____/_____