

PEDIATRIC HEALTH HISTORY

Child's Name: _____ Sex: Female Male Other
Parents: _____ Number of Children: _____
Address: _____ City/Province: _____ Postal Code: _____
H. Phone: _____ Date of Birth: ____/____/____ Age: ____
mm dd yr
Medical Doctor: _____ Last Visit to MD: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Alberta Health Care Number: _____ Whom may we thank for referring you? _____

EVENTS

There are many events that occur throughout childhood- starting with childbirth, then learning how to walk, and playing childhood sports. These events can cause accumulated stress and result in loss of health potential. A child's spine is like a growing tree- "*As the twig is bent, so grows the tree.*" Most times the effects are gradual, not even felt until we become adults. Answering the following questions will give us an understanding of your child's overall health and allow us to better assess their body's innate ability to be healthy. Please check ✓ the following.

Tell us about your pregnancy:

Did you carry to full term (40 weeks)? _____ If not, how many weeks gestation? _____
Did you consume alcohol during your pregnancy? _____ Did you smoke? _____
Did you take any medication during your pregnancy? Details: _____
Describe any complications and when they occurred: _____

Tell us about your labour and delivery of this child:

Did you use a midwife? _____ Obstetrician? _____ Home birth? _____ Hospital? _____
Did you have a C-Section? _____ Vaginal birth? _____
Were you induced? _____ Epidural? _____ Were forceps used? _____ Vacuum Extraction? _____
What was the baby's **APGAR** Score at 1 minute? ____/10 & at 5 minutes? ____/10 OR not sure _____
Was there initial respiratory delay? _____ Purple markings on face? _____ Mis-shaped skull? _____ Jaundice? _____
Describe any problems during labour and delivery? _____

Tell us about your child:

Did you breastfeed? _____ How long? _____ Bottle feed? _____ Formula? _____
Number of hours your child sleeps per night? _____ hrs. Quality of sleep: good _____ fair _____ poor _____
List any current medications or supplements your child is taking: _____
List any previous medication(s), for what condition, and the number of times it was prescribed: _____
List any emergency/hospital visits: _____

As a baby/toddler (birth-4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from change table/crib | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other _____ |

As a young child (5-12 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from tree/playground equipment | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Other _____ |

SYMPTOMS AND ILL HEALTH

As a child or adolescent, has your child experienced any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck/back pains | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other: _____ | |

Present reason for consulting our office:

- Maximizing personal and / or family health potential?
- Correction and prevention of an existing problem? *Please fill out the information below.*

If your child has symptoms or a complaint, briefly describe the problem here. _____

How and when did this problem start? _____

The problem is: Constant _____ Comes & Goes _____ Radiates/Travels (where?) _____

How long has this been going on? _____ Does this affect their sleep or mood? _____

If he/she is experiencing pain, is it: Sharp ___ Dull ___ Throbbing ___ Aching ___ Shooting ___ Nagging ___

What aggravates the condition / pain?

What relieves the condition / pain?

Please describe any past or current treatment(s) and results: _____

Is there anything else you would like us to know? _____
