Southside Chiropractic-Dr. Don MacDonald/Dr. Hailey Lutz

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: _____
yr mm dd

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 <u>current</u> medications or supplements your child is taking: _____

_____

List any <u>previous</u> 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?

___ Fall from change table/crib
___ Tumble down stairs
___ Involved in a car accident
___ Play in "Jolly Jumper"
___ Fall off playground equipment
___ Constipation
___ Frequent ear infections
___ Reaction to vaccination
___ Bed wetting
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Did not gain weight
___ Sleeping problems
___ Frequent colds
___ Colic
___ Other_____

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

___ Fall from tree/playground equipment
___ Fall off a bicycle
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Learning difficulties
___ Bed wetting
___ Hyperactivity/Autism
___ Asthma
___ Allergies
___ Leg/knee pains
___ Frequent colds
___ Other_____

SYMPTOMS AND ILL HEALTH

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

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Weight gain/loss
___ Arm/wrist pains
___ Neck/back pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Other: _____
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Shoulder pains
___ Fatigue
___ "Growing Pains"

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? _____

_____