WHALE FAMILY CHIROPRACTIC

Dr. Robin Whale & Dr. Caroline Taylor

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CHILD HEALTH HISTORY FORM

Child's Name:	DOB (D/M/Y):	Age:
Parent's Name:		
Address / Postal:		
Parent's Cell #:	Alternate Phone #:	
Email Address:	Can we text and/or email you? ☐ Yes ☐ No	

Emergency Contact Name:	Contact Number:
Relationship to child (e.g. parent, grandparent):	

Who may we thank for referring you to this office?

Parent/Guardian Signature: ____ **Date:** _________________________

HEALTH PROFILE

What's the reason for your child's visit today? ____

If your child doesn't have specific symptoms but you're interested in general wellness, check the box and proceed to page 2: ☐
Otherwise, please continue answering the following questions.

When did these health issue(s) occur/begin? ____

If this has happened before, when/how often? ____

Provide a number between 1 and 10 that best describes the severity of your child's discomfort: _____ (1 = MILD, 10 = SEVERE)

What make their symptoms feel worse? ____

What makes their symptoms feel better? ____

Has your child seen other health care providers for these issues? If so, what form(s) of treatment (e.g. massage, physiotherapy, medication) and what were the results?

____

____

Are there other things you do to help reduce your child's discomfort or improve general health (e.g. reduce stress, special diet)?

____

____

How is this condition affecting your child's ability to function at home/school/sports/activities, as applicable?

____

____

How does this issue affect other members of the family? Are there ways the family is having to change or adapt because of it?

____

____

Has your child been adjusted by a chiropractor before? ☐ Yes ☐ No If so, how often and for what length of time?

____

____

Results of chiropractic care (if applicable):

____

Has your child had spinal x-rays within the last 3 years? ☐ Yes ☐ No If so, can a copy be provided to us? ☐ Yes ☐ No

What level of care are you seeking for your child at this time?

- ☐ "Band-aid" Fix (just get rid of current symptoms)
- ☐ Corrective Care (aim to fix cause of symptoms)
- ☐ Wellness Care (improve overall health and vitality)

List any serious health conditions known in your child's immediate family history (parent, sibling, grandparent). For example, diabetes, scoliosis, migraines, etc.

____

____

What are a few specific goals you could incorporate into your child's life to improve their health? (e.g. drink more water, improve diet, exercise more, remove avoidable stresses). Would you like help from us with accountability on these goals? ☐ Yes ☐ No

____

____

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SYSTEM CHALLENGES

Has your child's body communicated any of the following symptoms?

While it may seem unrelated to the purpose of this visit, it helps us with your child's overall assessment and care plan.

Check ☑ the *symptoms affecting your child now*, and **add "P"** or **"R"** next to issues experienced **Previously** or **Repeatedly**

Nervous System

- ❑ Nervous/Anxious ___
- ❑ Numbness ___
- ❑ Paralysis ___
- ❑ Dizziness ___
- ❑ Depression ___
- ❑ Fainting ___
- ❑ Convulsions ___
- ❑ Cold/Tingling Extremities ___
- ❑ Stress ___
- ❑ Poor Focus/Concentration ___

Musculo-Skeletal

- ❑ Low Back Pain ___
- ❑ Pain Between Shoulders ___
- ❑ Neck Pain ___
- ❑ Leg Pain ___
- ❑ Arm Pain ___
- ❑ Joint Pain/Stiffness ___
- ❑ Difficult Chewing/Clicking Jaw ___
- ❑ Abnormal (Walking) Gait ___

General

- ❑ Fatigue ___
- ❑ Allergies ___
- ❑ Poor Quality Sleep ___
- ❑ Recurrent Fevers ___
- ❑ Headaches/Migraines ___

EENT

- ❑ Vision/Eye Problems ___
- ❑ Dental Problems ___
- ❑ Sore Throat ___
- ❑ Ear Aches/Infections ___
- ❑ Hearing Difficulty ___
- ❑ Stuffed Nose ___

Cardio-Vascular/Respiratory

- ❑ Irregular Heartbeat ___
- ❑ Other Heart Problems ___
- ❑ Lung Problems/Congestion ___

Gastro-Intestinal

- ❑ Poor/Excessive Appetite ___
- ❑ Excessive Thirst ___
- ❑ Frequent Nausea ___
- ❑ Recurrent Vomiting ___
- ❑ Diarrhea or Constipation ___
- ❑ Bed Wetting ___
- ❑ Weight Problems ___
- ❑ Abdominal Cramps/Bloat ___

FEMALES ONLY

If child has started menstruating:

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain / Infections

Please provide details, if applicable:

Learning Issues or Behavioural Challenges:

____

____

____

____

Other Notes or Comments:

____

____

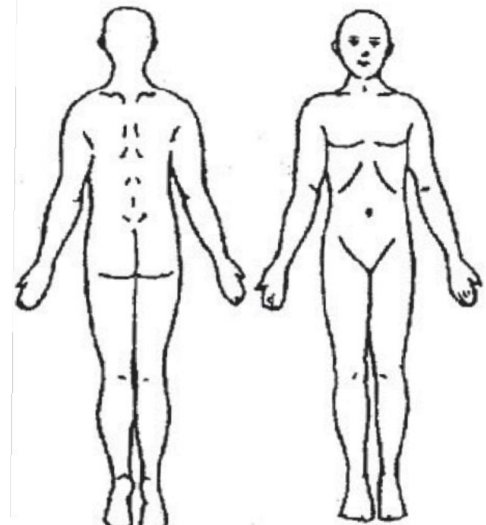
____

____

Please indicate on the diagram to the right any area(s) of discomfort for your child, including radiation of pain or numbness.

Circle = Aching
S = Sharp Pain
T = Tingling
R = Radiating
N = Numbness

NOTE: When using auto-fill PDF version of this form, <u>this diagram will need to be completed by hand on the printed hard copy.</u>



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STRESS PROFILE

The state of your child's body and health is a result of all that has happened to them up to this point in life. Sometimes the stresses they face can overwhelm the nervous system and their ability to heal and thrive is compromised. Details of these stressors will enhance our understanding of your child's current state of health.

PHYSICAL STRESSORS

Please describe the most significant physical stresses your child has faced during their life. List any serious accidents, injuries, broken bones, surgeries, etc. **Examples**: Significant or repeated falls as a child (from a height, down stairs, in sports), carrying a heavy backpack, sedentary lifestyle, extensive sitting (over 2 hours/day outside of school), slouching, demanding sports schedule.

____

____

Average number of screen time hours (phone, tablet, video games, etc.): Weekdays _____ Weekends _____

Birth History

Number of hours in labour: Total = _____ Active = _____ Induced: ☐ Yes ☐ No

Delivery type: ☐ Vaginal OR ☐ Cesarian (Planned) / ☐ Cesarian (Emergency)

Birth assisted by: ☐ Forceps ☐ Vacuum ☐ Birth attendant pulling on baby ☐ Nothing

Other complications of pregnancy or delivery? ____

CHEMICAL STRESSORS

Everything your child eats, drinks, breathes and touches can affect their health. Please describe the chemical stressors your child's body has encountered. **Examples**: Poor diet (not enough veggies), high sugar consumption, second-hand smoke, over-the-counter or prescription medication (inhalers, antibiotics, pain medication), low water consumption, alcohol and/or drug use.

____

____

Please list your child's medications and what they are for:

____

Please list any vitamins/supplements your child currently takes:

____

EMOTIONAL/MENTAL STRESSORS

Children face many emotionally stressful events in their lives. Please list any below, knowing they will be met without judgement. **Examples**: Difficult/unstable home environment, divorce, emotional or other abuse, bullying, anxiousness/shyness, low self-esteem, learning or school-related challenges.

____

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