Whitemud Crossing Chiropractors (3-14 Years)

DATE:______________________

PEDIATRIC HEALTH HISTORY

Child's Name: ____ Sex: Female ☐ Male ☐ Other ☐
Parents: ____ Number of Children: _____________
Address: ____ Home Phone: ___________________
City/Province: ________________________ Postal Code: ___________ Cell Phone: _____________________
Date of Birth: ___dd____/___mm____/___yy___ Age: _______ Height: ______________ Weight:______________
Medical Doctor: __________________________________ Last Visit to MD: __________________________
Emergency Contact: ____________________________ Phone: _______________ Relationship: __________
Alberta Health Care #: ___________________________
Whom may we thank for referring you? ____________________ ☐ Google ☐ Facebook/Instagram ☐Walked By
Has your child ever received chiropractic care? No ☐ Yes ☐
If yes: Dr. ____Approx. Date of Last Visit: ____________________

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 and 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)? ☐ Yes ☐ No If not, how many weeks gestation? _____
Did you consume alcohol during your pregnancy? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No
Did you experience any illnesses? ☐Yes ☐ No Details: ____
Did you take any medication during your pregnancy? ☐ Yes ☐ No Details: __________________________________
Was the baby ever in the breech position? ☐ Yes ☐ No
Describe any complications and when they occurred: ____
____

Tell us about your labour and delivery of this child:

Where was the child born? ☐ Hospital ☐ Birthing Center ☐ Home
Who assisted the birth? ☐ Obstetrician ☐ Midwife
Was the birth induced? ☐Yes ☐ No Was an epidural administered? ☐ Yes ☐ No
How long did labour last? _________
Was the birth ☐ Vaginal ☐ C-Section Were any devices used? ☐ Forceps ☐ Vacuum
Immediately after birth was there:
☐ Respiratory delay ☐ Purple markings on face ☐ Misshaped skull ☐ Jaundice
Describe any problems during labour and delivery: ____

Tell us about your child:

Did you: ☐ Breastfeed - How long? ________________________ ☐ Bottle fed – Formula___________________________
Number of hours your child sleeps per night? ________ Quality of sleep: ☐ Good ☐ Fair ☐ Poor
How would you rate your child's health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Was your child vaccinated? ☐ Yes ☐ No - List any vaccine reactions: _________________________________
Were you given an informed choice about vaccinating? ☐ Yes ☐ No
Is your child's life stressful: ☐ Yes ☐ No Is your life stressful? ☐ Yes ☐ No
Do you have any concerns about your child's development? ☐ Yes ☐ No Explain:_________________________
____
List any <u>previous</u> medication(s), for what condition, and the number of times it was prescribed: ____________________
____
List any emergency/hospital visits: ____

Whitemud Crossing Chiropractors (3-14 Years)

NAME______________________________

DATE:______________________________

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

☐ Car Accident(s) ☐ Fall from a change table or crib ☐ Fall from playground equipment
☐ Fall down the stairs ☐ Play in a "Jolly Jumper" ☐ Sit in a "Bumbo" ☐ Taken Antibiotics

Details:____
____

As a young child (5-14 years), did any of the following occur?

☐ Car Accident(s) ☐ Carried a backpack that was too big – If Yes: ☐ Lt Shoulder ☐ Rt Shoulder ☐ Both Shoulders
☐ Fall from a tree/playground equipment ☐ Fall off a bike ☐ Sports accidents ☐ Taken Antibiotics

Details:____
____

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

☐Allergies	☐Convulsions	☐Headaches	☐Paralysis	☐Weight Loss/Gain
☐Anemia	☐Developmental Delays	☐Heart Conditions	☐Poor Appetite	☐Other ____________
☐Arm Problems	☐Diarrhea	☐Hyperactivity	☐Weight Gain	________________
☐Asthma	☐Digestive Problems	☐Infections	☐Reaction to Vaccines	________________
☐Back Pain	☐Dizziness	☐Jaundice	☐Reflux	
☐Bed Wetting	☐Ear Infections	☐Joint Problems	☐Ringing in Ears	
☐Broken Bones	☐Eczema	☐Learning Disability	☐Shoulder Pain	
☐Colds/Flu	☐Excessive Crying	☐Leg Problems	☐Skin Issues	
☐Colic	☐Fatigue	☐Muscle Jerking	☐Sleep Problems	
☐Concussion	☐Frequent Fevers	☐Muscle Spasms	☐Stomach Pains	
☐Congenital Defects	☐Foot/Ankle/Knee Pain	☐Muscle Weakness	☐Tingling in Arms or Legs	
☐Constipation	☐"Growing Pains"	☐Neck Pain	☐Torticollis	

Details:____
____
____

REASON FOR SEEKING CARE

☐ Maximizing personal and / or family health potential?
☐ Correction and prevention of an existing problem? – *If you checked this box, please fill out the information below.*

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

How did this problem start? ____

When did this problem start? ____

The problem is: ☐ Constant ☐Comes & Goes ☐Radiates/Travels *(where?)* ___________________________
☐ Sudden ☐Gradual ☐Associated with an event?___________________________

Is the pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting ☐ Nagging

Duration of problem: ☐ Minutes ☐ Hours ☐ Days ☐ Months ☐ Years

What have you noticed makes the problem worse?____

What have you noticed makes the problem better? ____

How does the problem affect your child's body function and daily activities?
____

It interferes with: ☐School ☐Sleep ☐ Walking ☐Sitting ☐Hobbies ☐Sports ☐Other:____________________

Have you noticed this or a similar issue before? ____

Have you seen other health care professionals for this issue? ☐ Yes ☐ No

Who?____

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

Reviewed and discussed by chiropractor ________