

# Whitemud Crossing Chiropractors (Infant 0-2y/o)

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, 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?  Home  Birthing Center  Hospital  
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  
What was the baby's **APGAR** score at 1 minute? \_\_\_\_/10 & at 5 minutes? \_\_\_\_/10 OR  Not sure  
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

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NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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 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/infant, did any of the following occur?

- Car Accidents     Fall from a change table or crib     Fall from playground equipment  
 Fall down the stairs     Played in a "Jolly Jumper"     Sat in a "Bumbo Chair"     Taken Antibiotics

Details: \_\_\_\_\_

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

- |                                       |   |   |  |   |
|---------------------------------------|---|---|--|---|
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Colic                | <input type="checkbox"/> Ear Infections   | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Reflux             |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Congenital Defects   | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Skin issues/Rashes |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Excessive Crying | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Sleep problems     |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Convulsions          | <input type="checkbox"/> Frequent fevers  | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Stomach Pains      |
| <input type="checkbox"/> Bed Wetting  | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Infections       | <input type="checkbox"/> Muscle Jerking      | <input type="checkbox"/> Torticollis        |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Digestive Problems   | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Paralysis           | <input type="checkbox"/> Vaccine Reactions  |
| <input type="checkbox"/> Colds/Flu    | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> Other: _____       |

## 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.*

What are your chief concerns, if any, with your child's health? \_\_\_\_\_

How did this problem start? \_\_\_\_\_

When did this problem start? \_\_\_\_\_

The problem is:     Constant     Comes & Goes     Radiates/Travels (*where?*) \_\_\_\_\_  
 Sudden     Gradual     Associated w/ an event? \_\_\_\_\_

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

Duration of problem:     Minutes     Hours     Days     Months

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? \_\_\_\_\_

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 \_\_\_\_\_