

# Child Health History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Parent's Home Phone: \_\_\_\_\_ Parent's Work Phone: \_\_\_\_\_  
Parent's Names: \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_

## **Why This Form Is Important:**

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

## **Current Health Concern**

Health Concern: \_\_\_\_\_  
When did it begin? \_\_\_\_\_ How often does it occur? \_\_\_\_\_  
What relieves it? \_\_\_\_\_  
What aggravates it? \_\_\_\_\_  
Other Professionals Seen For Concern: \_\_\_\_\_  
Treatment and Results: \_\_\_\_\_

## **Birth History**

Child's gestational age at birth \_\_\_\_\_ weeks Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_  
Birth experience:  Midwife  Medical Labour:  Spontaneous  Induced  
Any procedures during birth?  Forceps  Vacuum Extraction  C-section  Episiotomy  
Any complications before or after birth?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Evidence of obvious birth trauma?  Bruising  Odd shaped head  Stuck in birth canal  Cord around neck

## **Family Health History**

Please note any health issues that are present with family relations:

Brothers: \_\_\_\_\_  
Sisters: \_\_\_\_\_  
Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Grandparents: \_\_\_\_\_

In this office we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.



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## Physical Stresses

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- Any significant falls or trauma to the mother during pregnancy?  Yes  No  Unsure  
For the child, were there any falls from couches, beds, change tables, etc?  Yes  No  Unsure  
Any hospital visits for concussions, possible fractures or other traumas?  Yes  No  Unsure  
Have there been any surgeries?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Is a backpack worn?  Yes  No If yes, is it  heavy or  light?  
Does your child participate in sports?  Yes  No  
Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)  
 Yes  No  Unsure

## Chemical Stresses

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- During pregnancy, did the mother: – use medications?  Yes  No If yes, which ones? \_\_\_\_\_  
– smoke?  Yes  No  
– drink?  Yes  No  
Was the child breast-fed?  Yes  No If yes, how long? \_\_\_\_\_  
Formula introduced at what age? \_\_\_\_\_  
Began solid foods at what age? \_\_\_\_\_  
Vaccination history: Vaccinations given: \_\_\_\_\_  
Any reactions?  Yes  No If yes, please list: \_\_\_\_\_  
Has the child been or is the child currently on any medications?  Yes  No  
If yes, please list: \_\_\_\_\_

## Mental/Emotional Stresses

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- Any problems with bonding?  Yes  No  Unsure  
Any behavioural problems?  Yes  No  Unsure  
Any night terrors, sleep walking, difficulty sleeping?  Yes  No  Unsure  
Average number of television hours per week? \_\_\_\_\_  
Do you feel that your child's social and emotional development is appropriate for their age?  Yes  No  Unsure

## Authorization For Care of a Minor (Under 16 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic staff.

Child's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

**Thank you for completing this form. If you have any further concerns, note them in the space below:**

