



PEDIATRIC HEALTH HISTORY FORM

Wihlidal Family Chiropractic 15 Matchedash St.N. Orillia, ON L3V 4T4



Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Parent Phone Numbers: (1) _____ (2) _____

Childs Sex: **M / F** Childs Birthdate: _____

Parents and Siblings Names: _____

Parents Email _____

Who may we thank for referring you? _____

THE PURPOSE OF THIS FORM

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.



#1 Current Health Concern (if there are no current symptoms and this assessment is to ensure optimum health and functioning, skip to section 2)

Health Concern: _____

When did it begin? _____ How often does it occur? _____

What relieves? _____ What aggravates? _____

Other professionals seen for concern _____

Treatment and results _____



#2 Birth History

Child's gestational age at birth _____ weeks Birth weight _____ length _____

Birth experience? Midwife or Medical Labour? Spontaneous or Induced

Any procedures during birth? **Forceps/Vacuum Extraction/C-section/Episiotomy**

Any complications before or after birth? Please explain _____

Evidence of obvious birth trauma? Bruising _____ Odd shaped head _____

Stuck in birth canal _____ Cord around neck _____

#3 Family Health History

Please note any health issues that are present with family relations

Brothers _____ Sisters _____

Mother _____ Father _____

Grandparents _____



(Please complete other side)



In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxations**. **Subluxations** are 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 answer the following questions to the best of your ability. This will help us to determine the causes of the **subluxations** we may find.

PHYSICAL STRESSES

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** Is it **light** or **heavy**? _____
Does your child participate in sports? **Yes No** If yes, which ones? _____
Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e./violin, gymnastics, etc.)
Yes No Unsure

CHEMICAL STRESSES

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** _____
Has the child been or is the child currently on any medications? **Yes No** If yes, please list _____

MENTAL/EMOTIONAL STRESSES

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

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

Authorization For Care of a Minor (Under 16 years of age)

Parent(s) Name(s) _____ hereby consent to the chiropractic assessment and care for our child at the Wihlidal Family Chiropractic Centre.

Parent Signature: _____ Date: _____ Witness Signature: _____