DISCOVER WELLNESS WITHIN
CHILD HISTORY FORM

M ☐
F ☐

Date: ________________ File No:____________________

PLEASE COMPLETE THIS DETAILED HISTORY FORM. SHOULD YOU REQUIRE ANY ASSISTANCE, PLEASE LET US KNOW, AS WE WOULD BE HAPPY TO ASSIST.

NAME ______________________________ TELEPHONE # _______________
ADDRESS ______________________ POSTAL CODE _______________
REFERRED BY _____________________ DATE OF BIRTH _______________
HEALTH CARD # ______________________ VERSION CODE ________
Expiry date of version code __________
Present MD and Address ____
Date of last MD visit & reason ____
Previous DC name and last visit ____
Present Length __________ Weight _____________

AUTHORIZATION FOR CARE OF A MINOR

PARENT(S) NAME(S) ____
Work telephone # ____________________ e-mail address _____________________
I hereby authorize and consent to the chiropractic evaluation and care of my child
Parent/Guardian signature _________________ Witness _____________________

CHIEF HEALTH CONCERNS

REASON FOR CONTACTING US ____

LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT
(including medications) ____
Date of Onset ___/___/___ Onset was: Sudden / Gradual / Associated with an event
Duration of problem (episode) _______minutes / hours / days / months / years
Pattern of problem: Constant / Intermittent / Occasional / Cyclical
Initiating factors: ____
Aggravating factors: ____
Relieving factors: ____
Effects of the problem on body function and daily activities: ______________________
____
Prior occurrence or episodes: ____

OTHER HEALTH CONCERNS ____
____
____
____
____

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Name:
Date:
File:

HISTORY OF BIRTH

Hospital Birthing Centre Home Medical Midwife
Duration of Gestation _________ weeks
Assisted birth: No / Yes If yes: forceps, vaccume extraction, c-section, induced labour
Medications delivered to mother at birth? Yes / No If yes, what? __________________
Duration of birth: ____
Complications at birth: Yes / No Explain ______________________________________
Was delivery normal? Yes / No ____
APGAR at BIRTH ___________________ AFTER 5 MINUTES __________________
BIRTH WEIGHT ____________________ BIRTH LENGTH _____________________

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? Yes / No
(Explain) ____
At what age did the child: Respond to sound _________ Follow an object __________
Hold up Head _______ Vocalize __________ Sit alone ________________
Teethe ____________ Crawl ____________ Walk ___________________
Do sleeping patterns seem normal to you: Yes / No Explain _______________________
Any health problems (cancer, diabetes, heart disease, etc) on the mother's side of the family _________________________ On the fathers side________________________
With siblings____
Problems that chiropractors concern themselves with can be related to many types of stressors. Please complete the following information, as it is very important in assessing your child's spinal health.

CHEMICAL STRSSORS

Was this baby breast-fed? Yes / No, How long ________________________________
Formula introduced at age _____ Type of Formula used ______________________
Introduced to cows milk at age ______
Began solid foods at age ___________ Type _______________________________
Age & Type of commercial baby food introduced ________________________________
Food / Juice intolerance No / Yes Type _______________________________________
During pregnancy did the mother smoke? Yes / No
Any illness of the mother during pregnancy: ___________________________________
Any supplements taken during pregnancy: _____________________________________
Any drugs taken during pregnancy: ____
Any exposures to ultrasound: No / Yes If so, how many and what was the medical reason?____
Any invasive procedures (amniocentesis, CVS): _________________________________
Any pets at home: No / Yes
Any smokers in the home: No / Yes (How much) ________________________________
Any vaccinations: Which ones and any reactions _______________________________
Any antibiotics: No / Yes Explain: ____
Total number of courses of antibiotics to date : _________________________________

Name:
Date:
File:

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation: No / Yes ____
Any problems with bonding: No / Yes ____
Any behavioural problems: No /Yes, Onset _____________________________________
Any night terrors, sleep walking, difficulty sleeping No / Yes, Specify ________________
Age of child when began daycare: ____
Average number of hours of television / week: _________________________________
Does your child seem normal for their age? Yes / No, Explain _____________________
____

TRAUMATIC STRESSORS

Any traumas during pregnancy (falls, accidents) ________________________________
Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other ______________

Any falls from couches, beds, change tables ___________________________________
Any traumas with bruising, cuts, stitches, fractures ______________________________

Any hospitalizations: Yes / No, Explain _______________________________________
Any surgeries or organs removed ____
Sports played and age began ____
Number of hours per week played ____
Weight of school backpack ____
Approx. hours spent at play per week ____

Thank you for completing this form, Please write any other questions you have below.
____
____
____

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