



CHILD HISTORY FORM

(Birth – 5 years old)

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www.carlislechiropractor.com

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is anything we can do to make your family feel more comfortable. To help us serve you better, please complete the following information. Should you require any assistance, please let us know as we would be happy to assist.

We look forward to working with your family towards *achieving optimal health, naturally.*

Date: _____

Referred By: _____

CHILD'S NAME: _____ Sex: Male Female

Date of Birth: _____

Name of Parent(s)/Guardian: _____

Address: _____ Postal Code: _____

_____ Phone: (Home) _____

(Work) _____

Present MD & address: _____

Date of last MD visit & reason: _____

Previous DC name & last visit: _____

AUTHORIZATION OF CARE FOR A MINOR

PARENT(S) NAME(S): _____

I hereby authorize and consent to the chiropractic evaluation and care of my child by Dr. David Veeneman of Carlisle Family Chiropractic. I acknowledge that I will have every opportunity to ask questions, clarify treatment methods and request additional resources as I deem necessary at any point during the care of my child.

Parent/Guardian Signature _____ Date: _____

Witness Signature _____ Date: _____

CHIEF HEALTH CONCERNS

Purpose for contacting us: _____

Have you seen other Doctors for this condition? If so, please list their names & treatments used

Date of Onset: _____ Onset was: Sudden Gradual Associated with event

Duration of problem (episode) _____ minutes hours days months years

Pattern of problem: Constant Intermittent Occasional Cyclical

Initiating factors: _____

Relieving factors: _____

Effects of problems on body function and daily activities: _____

Prior occurrence or episodes: _____

OTHER HEALTH CONCERNS

Please check any of the following conditions your child has suffered from:

- Ear Infections Scoliosis Temper Tantrums Bed Wetting
- Seizures Asthma or Allergies ADHD Headaches
- Chronic Colds Recurring Fevers Digestive Problems Car Accident
- Growing Pains Colic Other: _____

BIRTH HISTORY

Name of Obstetrician / Midwife: _____

Type of Birth: Normal Vaginal Forceps Breech Caesarean

Location of Birth: Home Hospital Other: _____

Duration of Gestation _____ weeks

Assisted Birth: No Yes

If yes: Forceps Vacuum Extractor C-Section Induced Labour

Complications during Pregnancy or Delivery? Please List.

Medications during Pregnancy / Delivery? Please List.

APGAR at Birth _____ after 5 minutes _____ Birth Length _____ Birth Weight _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? Yes No

Please explain: _____

At what age did your child:

- Respond to sound _____ Hold up the head _____ Teethe _____ Crawl _____
- Follow and object _____ Sit Alone _____ Vocalize _____ Walk _____

Do sleeping patterns seem normal to you? Yes No Please explain:

Has any family member ever been diagnosed with any of the following?

- Cancer Heart Disease Diabetes Stroke High Blood Pressure Other _____

Many of the ailments or conditions that children suffer from are the result of stressors on their bodies. In order for us to provide the very best care for your child, please complete the following information.

TOXIC (CHEMICAL STRESSORS)

Is/was this baby breast fed? Yes No For how long? _____
Formula introduced at age _____ Type of formula used? _____
Introduction to cow's milk at age _____
Began solid food at age _____ Type _____
Food or Juice Intolerances? Yes No Type _____
Rate your child's diet: Well-Balanced Average High sugar/processed foods
Any smoking by the mother during pregnancy? _____
Any illness of the mother during pregnancy? _____
Any supplements taken by mother during pregnancy? _____
Any drugs taken by mother during pregnancy? _____
Has your child been vaccinated? Yes No Which ones and were there any adverse reactions?

Has your child had antibiotics? Yes No How many times/ type of antibiotics?

Ultrasounds During Pregnancy? How many? _____
Any smokers in the home? Yes No How much? _____
Any pets in the home? Yes No How many and type? _____

THOUGHTS (PSYCHOLOGICAL STRESSORS)

Any difficulty with lactation? Yes No _____
Any behavioral problems? Yes No _____
Any night terrors, sleep walking, difficulty sleeping? Yes No _____
Average number of hours of television per week _____
Age of child when began daycare _____

TRAUMA (PHYSICAL STRESSORS)

Any traumas during pregnancy (falls or accidents)? _____
Any evidence of birth trauma:
 Bruising Odd shaped head Stuck in birth canal Fast birth Excessively long birth
 Respiratory Issues Cord around the neck Other _____
Any falls from the change table, beds, couches etc. . . Yes No _____
Any traumas with bruising, cuts, stitches, fractures Yes No _____

Any hospitalizations? Yes No _____
Any surgeries or organs removed? Yes No _____
Sports played and age that began _____
Weight of school backpack _____

Thank you for taking the time to complete our form. Please let us know if there are any other concerns or questions that you may have at this time.

