



CHILD HISTORY FORM

(6 – 12 years old)

Dr. David Veeneman, *B.Kin, M.Sc., D.C*

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: _____

PATIENT HISTORY

How would you describe the pregnancy? Normal Somewhat difficult Very difficult

How would you describe his/her infancy? Normal Somewhat difficult Very difficult

How would you describe his/her childhood? Normal Somewhat difficult Very difficult

If you answered anything other than 'Normal' please indicate why.

How would you describe his/her overall physical development? Above average Typical Below average

How would you describe his/her overall mental development? Above average Typical Below average

Is your child currently taking any medications? If so, how often and for what purpose?

Is your child currently taking any supplements or vitamins? If so, how often and for what purpose?

OTHER HEALTH CONCERNS

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

- Low self-esteem Scoliosis Irritability/Moodiness General Fatigue
- Seizures Asthma or Allergies ADHD Headaches
- Chronic Colds Recurring Fevers Digestive Problems Learning difficulties
- Growing Pains Depression/Anxiety Acne/Skin Issues Other: _____

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)

Introduction to cow's milk at age _____

Food or Juice Intolerances? Yes No Type _____

Rate your child's diet: Well-Balanced Average High sugar/processed foods

Any smokers in the home? Yes No How much? _____

Does your child smoke? _____

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?

Any pets in the home? Yes No How many and type? _____

THOUGHTS (PSYCHOLOGICAL STRESSORS)

Any difficulty with socialization at school? Yes No _____

Any behavioral problems? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Average number of hours of television per week _____

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 trees, 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.

