CHILD HISTORY FORM

(Birth – 9 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
maximizing your child's health potential, naturally.

Date: ________________________ Referred By: ______________________________

CHILD'S NAME: ____ Sex: Male ☐ Female ☐ Prefer not to answer ☐
Date of Birth: ____ Age: _____________

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 drugs, medications or supplements taken by mother during pregnancy? ____________________________________
Has your child been vaccinated? ☐ Yes ☐ No Did your child experience 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 ____________________________
Any problems with other kids or teachers at school? ____
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 ____

TECHNOLOGY

Does your child engage in any of the following technology? If yes, how many hours per day?
☐ television _____ ☐ video games _____ ☐ iPads/tablets _____ ☐ mobile phone _____ ☐ other _____
Are you aware of changes in your child's behaviour/mood with prolonged periods of 'screen time?' ☐ yes ☐ no

Is there anything else that you would like to discuss about your child's well-being?

Dr. David Veeneman, 1490 Centre Road, Carlisle, ON, L0R 1H2, P: 905-689-5100 carlislechiropractic@cogeco.net