CHILD HISTORY FORM

(10 – 17 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: _________________________

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

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)

Was this child breast fed? ☐ Yes ☐ No For how long? ______________________________
Introduction to cow's milk at age _____________
Any smoking by the mother during pregnancy? ____
Any illness of the mother during pregnancy? ____
Any drugs, medications or supplements taken by mother during pregnancy? _____________________________________
Food or Juice Intolerances? ☐ Yes ☐ No Type ____
Rate your child's diet: ☐ Well-Balanced ☐ Average ☐ High sugar/processed foods
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?_____________________________
Any smokers in the home? ☐ Yes ☐ No How often do they smoke inside? _____________________________________
Does your child smoke/vape or use recreational drugs? ☐ Yes ☐ No ____
Any pets in the home? ☐ Yes ☐ No How many and type? ____

THOUGHTS (PSYCHOLOGICAL STRESSORS)

Any difficulties at school? ☐ Yes ☐ No ____
____
Any behavioral problems? ☐ Yes ☐ No ____
Any night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No ____
Does your child have good, interpersonal relationships at school? ☐ Yes ☐ No ________________________________

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?

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