

# Child History Form

Date: \_\_\_\_\_

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Address: \_\_\_\_\_

Name of Previous Doctor of Chiropractic: \_\_\_\_\_

Date of Last Visit (dd/mm/yyyy): \_\_\_\_\_

Child's Height: \_\_\_\_\_

Child's Weight: \_\_\_\_\_

Name(s) of Parent(s) or Guardian(s): \_\_\_\_\_

Business Telephone: \_\_\_\_\_

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

What are your chief concerns, if any, with your child's health?

\_\_\_\_\_

What is your main reason for contacting us?

\_\_\_\_\_

List any other care your child has undergone with regards to this complaint including medication:

\_\_\_\_\_

Date of onset (mm/yyyy): \_\_\_\_\_

Onset was: (circle one)		
Sudden	Gradual	Associated with an event

Duration of problem or episode: (circle one)				
Minutes	Hours	Days	Months	Years

Pattern of Problem: (circle one)			
Constant	Intermittent	Occasional	Cyclical

Initiating Factors: \_\_\_\_\_

Aggravating Factors: \_\_\_\_\_

Relieving Factors: \_\_\_\_\_

How does the problem affect your child's body function and daily activities?

Prior occurrence or episodes? \_\_\_\_\_

Other health concerns? \_\_\_\_\_

## History of Birth

Hospital / Birthing Center:  Home  Medical  Midwife Duration of Gestation: \_\_\_\_\_ weeks

Was the birth assisted?  Yes  No If yes, how?  Forceps  Vacuum Extraction  C-Section  Induced Labour

Were medications given to the mother at birth?  Yes  No If yes, what? \_\_\_\_\_ Duration of Birth: \_\_\_\_\_

Was the delivery normal?  No  Yes If no, what complications were there at birth? \_\_\_\_\_

APGAR at Birth \_\_\_\_\_ APGAR after 5 minutes \_\_\_\_\_ Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_

### Growth and Development

Was the infant alert & responsive within 12 hours of the delivery?  Yes  No If no, explain: \_\_\_\_\_

At what age did the child: Respond to sound? \_\_\_\_\_ Follow an object? \_\_\_\_\_ Hold up head? \_\_\_\_\_ Vocalize? \_\_\_\_\_

Sit alone? \_\_\_\_\_ Teethe? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_ Do his/her sleeping patterns seem normal?  Yes  No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) \_\_\_\_\_

The father's side? \_\_\_\_\_

Do the child's siblings have any health problems?  Yes  No If yes, describe: \_\_\_\_\_

*The following information is very important because many of the problems that chiropractors work with are caused by stressors.*

### Chemical Stressors

During pregnancy, did the mother: 1. Smoke  Yes  No 2. Drink alcohol?  Yes  No 3. Take supplements/vitamins?  Yes  No

4. Take drugs?  Yes  No If yes, what? \_\_\_\_\_ 5. Become ill? If so, how? \_\_\_\_\_

5. Receive ultrasounds?  Yes  No If yes, how many? \_\_\_\_\_ 6. Receive invasive procedures (ie. amniocentesis, CVS)?  Yes  No

Was your child breast fed?  Yes  No If yes, for how long? \_\_\_\_\_ weeks months years

At what age was: 1a. Formula introduced? \_\_\_\_\_ b. Brand? \_\_\_\_\_ 2. Cow's milk? \_\_\_\_\_ yrs 3. Solid foods? \_\_\_\_\_ yrs

Did your child receive vaccinations?  Yes  No If yes, which ones? \_\_\_\_\_ Did your child react to them?  Yes  No

Has your child had antibiotics?  Yes  No If yes, how many courses has the child had so far & why? \_\_\_\_\_

Any pets at home?  Yes  No Any smokers at home?  Yes  No If yes, how much? \_\_\_\_\_

### Psychological Stressors

Any difficulties with lactation?  Yes  No Any problems bonding?  Yes  No Does your child seem normal to you?  Yes  No

Does the child have any behaviour \_\_\_\_\_

problems?  Yes  No If yes, what? \_\_\_\_\_

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)?  Yes  No If yes, specify: \_\_\_\_\_

Did your child go to daycare?  Yes  No From what age? \_\_\_\_\_ yrs Average no. of hours of TV/Computer per week? \_\_\_\_\_ hrs

### Traumatic Stressors

Any evidence of trauma during birth?  Bruises  Odd shaped head  Stuck in birth canal  Fast and/or excessively long birth

Respiratory Depression  Cord around neck  Other \_\_\_\_\_

Any falls/accidents during pregnancy?  Yes  No Has the child had any major falls since birth?  Yes  No If yes, did the child need stitches or cause a fracture? Please describe: \_\_\_\_\_

Any hospitalizations?  Yes  No Please explain: \_\_\_\_\_

Does your child play sports?  Yes  No Number of hours per week? \_\_\_\_\_ Age child began \_\_\_\_\_ yrs

Weight of school backpack? \_\_\_\_\_ lbs Approx. Hours spent at play per week? \_\_\_\_\_ hrs