# Child History Form

*Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.*

Child's Name:______________________________________________________Date: _____________________

Parent(s) Name:_____________________________________________________________________________

Sibling(s) Name(s) (Ages):______________________________________________________________________

Address: ____________________________________________City:__________________ Prov. ___________

Postal Code:____________Home Phone: (____)__________________ Bus Phone: (____)_________________

Date of Birth: ____________________ Age: ____ Gender: ☐ M ☐ F Referred by: ____________________

Health Card Number: ____________________________ Version Letter(s): _______ Exp Date: ______________

Has your child ever received chiropractic care? ☐ Yes ☐ No If yes, previous DC's name and last visit date?

_____________________________________________________________________________________________

Name of Medical Doctor: ___________________________________________________________________

e-mail address:__________________________Would you like to be a member of our website? Yes:___No: ____

**AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)**

PARENT(S) NAME(S): _______________________________________WORK TEL:_________________

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

PARENT/GUARDIAN SIGNATURE: __________________________________________ DATE: ________

WITNESS SIGNATURE: ___________________________________________________________________

## Present Health Complaints/Concerns:

Major: ____________________________________________________________________________________

_____________________________________________________________________________________________

Minor: ____________________________________________________________________________________

_____________________________________________________________________________________________

When did this problem begin? _______________________________________________________________

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does problem radiate? ☐ Yes ☐ No If yes, where? ___________________________________________

What makes this worse? ____________________________________________________________________

What makes this better?_____________________________________________________________________

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? ____________________

Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?

Is this becoming worse?_____________________________________________________________________

Other professionals seen for this condition? ___________________________________________________

Results with that treatment?_________________________________________________________________

_____________________________________________________________________________________________

© Chiropractic Excellence

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Loss Of Taste | ☐ Weight Gain | ☐ Upper Back Pain |
| ☐ Dizziness | ☐ Light Sensitivity | ☐ Dental Problems | ☐ Neck Pain |
| ☐ Fainting | ☐ Face Flushed | ☐ Fevers | ☐ Low Back Pain |
| ☐ Fatigue | ☐ Cold Sweats | ☐ Heart Palpitations | ☐ Radiating Pain |
| ☐ Irritability | ☐ Bronchitis | ☐ Chest Pressure | ☐ Stiffness |
| ☐ Depression | ☐ Pneumonia | ☐ Breast Pain | ☐ Reduced Mobility |
| ☐ Loss Of Balance | ☐ Difficulty Breathing | ☐ Frequent Colds | ☐ Numbness In Leg(s) |
| ☐ Loss Of Concentration | ☐ Shortness Of Breath | ☐ Sinus Congestion | ☐ Numbness In Feet |
| ☐ Loss Of Memory | ☐ Asthma | ☐ Sore Throats | ☐ Numbness In Hand(s) |
| ☐ Ears Buzzing | ☐ Urinary Problems | ☐ Ear Pain / Infections | ☐ Weakness |
| ☐ Poor Coordination | ☐ Constipation | ☐ Allergies | ☐ Muscle Cramps |
| ☐ Vision Changes | ☐ Diarrhea | ☐ Heartburn | ☐ Sleeping Problems |
| ☐ Loss Of Smell | ☐ Weight Loss | ☐ Bloating / Gas | |

☐ Other:______________________________________________________________

## History of Birth

What was the child's gestational age at birth? ________ Weeks.

Birth weight _____ lbs. ______ oz.__________ Birth length ______ inches

Was your child's birth ☐ at home ☐ in a birthing center ☐ in a hospital

Was the birth considered ☐ medical ☐ midwife

What was the duration of the labour and birth? ______ hours

Was child born ☐ Cephalic (head first) ☐ Breech (feet first)

Were there any complications? ☐ Yes ☐ No If yes, please explain ______________________________

______________________________________________________________

Please check any assistance which was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

Was labour ☐ Spontaneous ☐ Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No If yes, what was given? ____

______________________________________________________________

APGAR score: at Birth_______/10 After 5 minutes______/10

## Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _______

______________________________________________________________

At what age did the child: Respond to sound_____ Follow an object _____Hold up head______Vocalize______

Sit alone ____________ Teeth _____________Crawl____________Walk ________

Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No If no, please explain_________________

______________________________________________________________

© Chiropractic Excellence

## Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family ______________________________

Father's family ______________________________

Sibling(s) ______________________________

**Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.**

## Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) ☐ Yes ☐ No If yes, please explain ______________________________

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal

☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

Any falls from couches, beds, change tables, etc? ☐ Yes ☐ No If yes, please explain ______________________________

Any traumas resulting in bruises, cuts, stitches, or fractures? ☐ Yes ☐ No If yes, please explain ______________________________

Any hospitalizations or surgeries? ☐ Yes ☐ No If yes, please explain ______________________________

Any sports played? ______________________________

Is a school backpack used? ☐ Yes ☐ No If yes, is it ☐ Heavy ☐ Light

## Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? ______________________________

Formula introduced at what age? ______________ What formula? ______________

Introduction of cow's milk at what age? ______________________________

Began solid foods at what age? ______________ Type of foods? ______________

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type? ______________________________

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? __________

drink? ☐ Yes ☐ No How much? __________

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? ______________________________

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? ______________________________

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? ______________________________

© Chiropractic Excellence 

Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? ________________________________

________________________________________________________________________________________________

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain ___

________________________________________________________________________________________________

Any pets at home? ☐Yes ☐No If yes, what kind(s)? ________________________________________________

Any smokers in the home? ☐Yes ☐No

## Vaccination History

Vaccinations and age given? ________________________________________________________________

Any negative reactions? ☐Yes ☐ No If yes, what were they?________________________________________

Any antibiotics given? ☐Yes ☐ No Reason? ______________________________________________________

## Psychosocial Stressors

Any difficulties with lactation? ☐Yes ☐ No If yes, what are they? ______________________________

Any problems with bonding? ☐Yes ☐ No If yes, what are they? ______________________________

Any behavioural problems? ☐Yes ☐ No If yes, what are they? ______________________________

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? ___________

Average number of hours of television per week? _____________

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No If yes, how?________________________________________________________________________________

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.