ALLISTON CHIROPRACTIC WELLNESS CENTRE

98 Victoria Street East, Alliston, ON L9R 1L1

Today's Date:

CONFIDENTIAL CHILD PATIENT HEALTH RECORD

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

Child's Name _____ Birth Date _____ Gender _____

Address _____ City/Town _____ Postal Code _____

Phone (Home) _____ Cell _____ Email _____

Name of Parents/Guardian _____

Siblings Names _____

Emergency Contact _____ Phone _____ Relationship _____

Whom shall we thank for referring you to our office? _____

Reason for consulting our office today: _____

Previous Chiropractor's Name & Date of Last Visit: _____

Name of Medical Doctor _____

Date of last MD visit and reason _____

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 - ○ eating? ○ daily routine? ○ sleep?

Is this becoming worse?

Other professionals seen for this condition _____ Results with that treatment _____

FAMILY HEALTH HISTORY

Please note any health problems (i.e. cancer, hereditary conditions, diabetes, heart disease, etc.).

Mother's Family _____

Father's Family _____

Siblings _____

Child/Youth History Form

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS.
(please tick 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: _____			

<u>HISTORY OF BIRTH</u> (For Children 0-6)

Child's gestational age at birth _____ weeks
Duration of the labour and birth _____ hours
Newborn Stats Length _____ inches Weight: __lbs __oz
Child's Birth Place ○ at home ○ in a birthing centre ○ in a hospital
This birth was attended by ○ Midwife ○ Medical Doctor
This child was born ○ cephalic (head first) ○ breech (feet/bum first)
Were there any complications at the time of birth? Please explain. _____

Assistance used during the birth ○ Episiotomy ○ Forceps ○ Vacuum Extraction ○ C-section

Labour began ○ spontaneous (on its own) ○ induced (method)

Medications or epidurals given to the mother during birth ○ Yes ○ No If yes, name of medication _____

APGAR Scores (if known) at Birth ___/10 After 5 minutes ___/10

GROWTH & DEVELOPMENT (For Children 0-6)

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	_____	Teethe	_____
Crawl	_____	Walk	_____		_____

Do you consider the child's sleeping pattern normal? ○ *Yes* ○ *No*
If no, please explain _____

Child/Youth History Form

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 (For Children 0-6)

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) ○ *Yes* ○ *No* If yes, please explain: _____

Any evidence of birth trauma to the infant?

○ bruising ○ stuck in birth canal ○ odd shaped head
○ 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? ○ *Yes* ○ *No* Please list: _____

PSYCHOSOCIAL STRESSORS (For Children 0-6)

Any difficulties with lactation? ○ *Yes* ○ *No*
Any behavioral problems? ○ *Yes* ○ *No*
Any night terrors, sleep walking, difficulty sleeping? ○ *Yes* ○ *No*
Any problems with bonding? ○ *Yes* ○ *No*
Age of child when 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*

CHEMICAL STRESSORS (For Children 0-6)

Was this child breastfed? ○ *Yes* ○ *No* If yes, how long? _____
Any antibiotics given? ○ *Yes* ○ *No* If yes, why? _____
Any vaccines given? ○ *Yes* ○ *No* If yes, what type? _____
Food/Juice intolerance? ○ *Yes* ○ *No* If yes, what type? _____
During pregnancy, did the mother:
- smoke? ○ *Yes* ○ *No* If yes, how much?
- drink? ○ *Yes* ○ *No* If yes, how much _____

Any illnesses during the pregnancy? ○ *Yes* ○ *No*

Any drugs taken during pregnancy? ○ *Yes* ○ *No*

Any ultrasounds? ○ *Yes* ○ *No* How many? Reasons? _____

Any invasive procedures during pregnancy (i.e. amniocentesis, CVS, etc.)? ○ *Yes* ○ *No*

_____ _____
Patient (Parent/Guardian) Signature Date