



Child (0-13yrs) History Form

Please take a few moments to complete this questionnaire for your child. Your answers will help us to determine if we can accept your child's case. If we sincerely believe that your child's condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with this form, please do not hesitate to ask. THANK YOU.

Personal Information

Child's Name _____ Gender M F Date _____

Parent/Guardian _____ Parent/Guardian _____

Siblings names & ages _____

Date of Birth D _____ M _____ Y _____ Age _____

School and Grade (if applicable) _____

Address _____

City/Prov. _____ Postal Code _____

Home Phone _____ Parent Mobile _____

Parent's Business/Employer _____ Business Phone _____

May we call you at work? No Yes

***Parent Email Address** _____

I AGREE to receive doctor and office correspondence (email addresses will not be shared with anyone outside of this office)

Referrals are our highest compliment; please share with us where you heard about our office:

- Current patient/a Friend – name: _____
 Website Google search Social Media (FB/IG) Yellow Pages Online Yellowpages.com
 Beacon Phonebook Family Doctor _____ Midwife _____
 Other - please specify _____

Reason for consulting this office:

- Wellness Prevention Symptom Relief

Current Health Information

Name of child's Medical Doctor & city _____

Date of last physical examination _____

Is the primary reason for your child being here a Wellness Check? (Circle one) Yes No

If No, What is reason you have brought your child to see us? _____

When did this problem begin? _____

Has this occurred before? Yes No Please describe when _____

How often does it happen? Constant Daily Few times per week Few times per month Other _____

Is it getting: Worse Better Constant Comes and goes

What aggravates the condition? _____

What relieves the condition? _____

Are there other areas of concern with this child? _____

Other doctors/therapists seen for these conditions? No Yes

Who? _____ When? _____

How does this condition affect this child's:

Ability to sleep? _____

Ability to eat? _____

Behaviour? _____

Ability to play? _____

Does this child currently take any medications? No Yes _____

Does this child currently take any natural supplements No Multivitamins Omega 3 Other _____

Is this child currently breastfeeding? Yes No If yes, how often? _____

In the past, did this child breastfeed? Yes No If Yes, for how long? _____

What is your personal satisfaction with this child's diet?

Highly satisfied Satisfied Dissatisfied Highly dissatisfied Why? _____

If older than 6 months, please answer the following:

How often does your child eat vegetables? Daily Weekly Almost never

How often does your child eat meat or other proteins? Daily Weekly Almost never

How often does your child eat foods containing healthy fats? (nuts/seeds/avocado/oils/yogourt etc)

Daily Weekly Almost never

How often does your child consume foods with added sugars? (juice, yogourts, kid snacks, candy, chocolate etc)

Daily Weekly Almost never

On average, how often does this child have bowel movements? _____

Does this child have any difficulty associated with bowel movements? _____

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur

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Is this child currently involved with any sports or physical activities No Yes _____ 3

On average, how much daily physical activity does this child have? 0-30min 30-60min 1-2h 2-4h over 4h
On average, how much screen time (devices, TV, gaming) does this child have daily?
 0-2h 2-4h 4-6h over 6h _____

Please rate the quality of this child's sleep: Poor Fair Good Excellent
Number of sleeping hours at night: _____ Number of napping hours during the day: _____

Has this child been exposed to second hand smoke? No Yes _____
How many times per year, on average, does your child get sick? _____
Do you have any concerns about your child's temperament/behaviour? No Yes _____

Please check if this child has EVER had any of the following:

- | | | | |
|---|--|--|---|
| Musculoskeletal | Cardiovascular/Respiratory | Gastro-Intestinal | General |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bloating/Gas | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Jaw pain/clicking | Eyes/Ears/Nose/Throat | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Growing pains | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Heartburn | <input type="checkbox"/> High stress _____ |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Reflux | <input type="checkbox"/> Frequent Fevers |
| Nervous system | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Difficulty breastfeeding |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Earache/infection | | <input type="checkbox"/> Emotional Traumas |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Hearing loss | | |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sinus congestion | | |

Does this child suffer from any other health conditions? _____

Birth History

Birth weight: _____ Birth length: _____ Arrival time: _____ wks
Position at birth: Vertex (head down) Breech (bum down)
Other _____ Posterior (face-up) Transverse Face / Brow first
Was labour: Spontaneous OR Induced → Membranes ruptured Cervical gel Pitocin Other
If induced, do you know why? _____

Any Interventions used: Forceps Vacuum extraction Manual pulling by doctor Epidural None
Type of Birth: Vaginal C-Section Duration of labour: _____
Location: Home Hospital Assisted by: Midwife _____ Doctor

Any complications during/after delivery: None Bruising of face/head Respiratory distress

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Difficulty breastfeeding Other _____ 4

Any problems during pregnancy with this child? Fall onto buttocks Low back pain Gestational diabetes
 Hypertension Car accident High Stress Other _____

Past Health History

Please describe any previous traumas and years:

Motor Vehicle Accidents (even minor ones) _____ Sports injuries _____
 Childhood traumas/falls (from beds/tables/down stairs/off swings/bikes etc. _____
 Birth injuries _____ Other: _____

At what age did this child: Hold up head _____ Sit alone _____ Crawl _____
Stand _____ Walk alone _____

Has this child ever been to a Chiropractor? No Yes Name/date _____
As a parent, have YOU ever been to a Chiropractor? No Yes Name/date _____
Has this child ever had any other sort of medical and/or alternative treatments? _____

Has this child ever had any x-rays taken? No Yes Of what area(s)? _____
Has this child ever been hospitalized or had any surgical operations? No Yes _____
Has this child ever had ear infections? No Yes How many and when? _____
Has this child ever been prescribed antibiotics? No Yes Approximate dates and reasons: _____

Has this child ever been prescribed any other medications? No Yes _____

Vaccination history

I have chosen not to vaccinate this child I have not decided yet Full schedule suggested by my doctor
Have you chosen any additional vaccines for this child? No Flu vaccine Hep A HPV other _____
Have you chosen to opt out of any vaccines for any reason? _____
Has your child ever had any known side effects to any vaccines? No Yes
If yes, please give dates, vaccine type and side effects: _____

Family Health History

Is there a family history of any of the following conditions?:
 Obesity Allergies Heart disease Arthritis Osteoporosis Cancer Diabetes
 Other _____

Thank you for your patience and cooperation in completely filling out this form. The details allow us to perform a specific physical examination, and monitor your child's progress through the stages of care. If you have any questions, please feel free to ask.

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Consent for Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined by Dr. Tanya Chambers, Dr. Mike Chambers, Dr. Pip Penrose and/or Dr. Blair Neely at the Stratford Chiropractic & Wellness Centre. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctors named above to determine what the best course of treatment would be in your child’s individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child’s spine and extremities, various orthopedic and neurological tests, and palpation of your child’s joints and muscles using our hands. The chiropractic examination is a “hands-on” approach so that we can best assess your child’s health. The examination may also include a computerized CoreScore scan, as well as necessary x-rays if indicated (rare).

Child Name

Parent/Guardian Name

Parent/Guardian Signature

Date

Doctor Witness Signature

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