Chiropractic Associates of Port Colborne

(Pediatric History Form)

It is a pleasure to welcome you to our family of happy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build a better health for your family

Patient name:_____

Address:_____ City:_____

Province:_____ Postal code:_____ Home Phone:_____

Full name on health card:_____ Date of birth (d/m/y):_____

Health card number:_____ Version code:_____

Names of parents/guardians:_____ Parent's email:_____

Parents employed at:_____ Work phone:_____

Referred to our office by:_____

Who is responsible for your bill? ❑ Parent ❑ Extended insurance ❑ Other:_____

How will payment be made? ❑ Cash ❑ Interac ❑ Visa ❑ Mastercard

Purpose for contacting us?_____

Other doctors seen for this condition? ❑ Y ❑ N Doctors' names and prior treatments:_____

_____

Other health problems?_____

Check any of the following conditions your child has suffered from during the past six months:

❑ Ear infections ❑ Scoliosis ❑ Seizures ❑ Chronic colds ❑ Headaches ❑ Asthma/Allergies ❑ Digestive problems

❑ ADHD ❑ Recurring fevers ❑ Growing/back pains ❑ Colic ❑ Bed wetting ❑ Car accident ❑ Temper tantrums

❑ Other_____

Previous chiropractor:_____ Date of last visit:_____/_____/_____

Reason:_____

Name of pediatrician:_____ Date of last visit:_____/_____/_____

Reason:_____

Are you satisfied with the care your child received there? ❑ Y ❑ N

Number of doses of antibiotics your child has taken:

During the past 6 months?_____ Total during their lifetime?_____

Number of doses of other prescription medications your child has taken:

During the past 6 months?_____ Total during their lifetime?_____ List:_____

Vaccination history:_____

Prenatal History:

Name of obstetrician/midwife:_____

Complications during pregnancy? ❑ Y ❑ N List:_____

Ultrasounds during pregnancy? ❑ Y ❑ N How many:_____

Medications during pregnancy/delivery? ❑ Y ❑ N List:_____

Cigarette/alcohol use during pregnancy: ❑ Y ❑ N

Location of birth ❑ Hospital ❑ Birthing center ❑ Home

Birth intervention ❑ Forceps ❑ Vacuum extraction ❑ Caesarean section (emergency or planned?_____)

CONTINUED ON REVERSE

Complications during delivery? ❑ Y ❑ N List:_____

Genetic disorders or disabilities? ❑ Y ❑ N List:_____

Birth weight:_____ Birth length:_____ APGAR scores:_____

Feeding History:

Breast fed: ❑ Y ❑ N How long:_____

Formula fed: ❑ Y ❑ N How long:_____ Type(s):_____

Introduced to solids at _____ months, cows' milk at _____ months

Food allergies or intolerances: ❑ Y ❑ N List:_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve reference). At what age was your child able to:

_____ Respond to sound _____ Cross crawl _____ Respond to visual stimuli

_____ Stand alone _____ Hold head up _____Walk alone _____Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (eg. A bed, changing table, down stairs, etc.) Was this the case with your child ❑ Y ❑ N

Is/has your child been involved in any high impact or contact type sports (eg. Soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ❑ Y ❑ N List:_____

Has your child ever been involved in a car accident? ❑ Y ❑ N List:_____

Has your child been seen on an emergency basis? ❑ Y ❑ N List:_____

Other traumas not described above? ❑ Y ❑ N List:_____

Prior surgery? ❑ Y ❑ N List:_____

Menarche? ❑ Y ❑ N Age:_____

Childhood Disease:

Chicken Pox	N / Y, Age:_____	Mumps	N / Y, Age: _____
Rubella	N / Y, Age:_____	Whooping cough	N / Y, Age: _____
Rubeola	N / Y, Age:_____	Other	N / Y, Age: _____

We are here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine your results.

Authorization for care of minor

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____

Signature Date

_____

Witness