CHILD HEALTH HISTORY FORMS 2-17 YEARS

Date: _____

At Parascak Family Chiropractic we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you into this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Daily, we experience physical, emotional, and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced throughout his/her lifetime, allowing us to better assess the challenges to his/her health potential.

Child's Name: _____

Address: _____ City: _____ Prov: _____

Postal Code:_____ Date of Birth (M/D/Y): _____ Age: _____

Sex: □ M □ F Height: _____ Weight: _____

Extended Health Care: □ No □ Yes Alberta Health Care #: _____

Mom's Name: _____ Mom's Phone #: _____

Dad's Name: _____ Dad's Phone #: _____

Mom's/Dad's Email (for in office use only): _____,_____

Previous Chiropractor: _____ Last Visit: _____

Referred to this office by: _____

THE BEGINNING YEARS (up to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

CHILDHOOD HISTORY

- ☐ Born by Vacuum
- ☐ Born by Forceps
- ☐ Born by Caesarean
- ☐ Born Breech
- ☐ Stomach sleeper as a child
- ☐ On Antibiotics as a child
- ☐ Used puffers as a child
- ☐ Vaccinations as a child
- ☐ Eat unhealthy foods
- ☐ Little to no exercise
- ☐ Home Stress
- ☐ Physical Stress
- ☐ Computer
- ☐ Sit mostly
- ☐ Stand mostly

Genetic disorders: _____

Childhood illnesses: _____

Childhood surgeries:_____

_____

Childhood injuries, falls:_____

_____

Contact Sports:_____

Hobbies:_____

_____

# of Medications/day:_____ What does he/she take medications for? 1 _____ 2 _____

3 _____4_____

Sports/Hobbies_____

_____

Car Accidents _____ When _____

Briefly describe_____

_____

Falls/Injuries _____When_____

Briefly describe_____

_____

CURRENT LIFESTYLE

Your child's current lifestyle determines how healthy he/she is now and how well his/her body will heal. Please rate your child's current health on a scale of **0 (poor) – 10 (optimal)**.

Diet _____ **Exercise** _____ **Sleep** _____ **Emotional/spiritual** _____

Many times, symptoms indicate a long-standing spinal condition. Please check off any symptoms your child has now or has experienced in the past.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Difficulty Breathing/sinuses
☐	☐	Fatigue	☐	☐	Asthma
☐	☐	Irritability	☐	☐	Frequent colds/flues
☐	☐	Depression	☐	☐	Ulcers
☐	☐	Neck Pain	☐	☐	Digestive problems
☐	☐	Dizziness	☐	☐	Low Back/Hip Pain
☐	☐	Loss of Concentration	☐	☐	Constipation
☐	☐	Difficulty Sleeping	☐	☐	Diarrhea
☐	☐	Mid Back Pain	☐	☐	Menstrual pain
☐	☐	Arm/hand pain or numbness	☐	☐	Leg/foot pain or numbness
☐	☐	Chest pain	☐	☐	Cancer
☐	☐	Heart Problems	☐	☐	Diabetes
☐	☐	Heartburn	☐	☐	Stroke
☐	☐	Skin problems	☐	☐	Bladder/urinary tract problems

Please describe the location of your child's symptoms or reasons for making this appointment:

_____

_____

How long has he/she had this condition? _____

Has he/she had a similar condition in the past? _____

What makes it worse? _____

What relieves it? _____

Do you feel his/her symptoms have been getting: □ better □ same □ worse?

Is the pain: □ sharp □ dull □ burning □ tight □ throbbing □ numb?

Is this condition interfering with his/her: □ work □ home routine □ family □ school ?

What doctors have you seen about this condition? _____

Have you seen a Chiropractor before? □ No □ Yes, When? _____

Approximately how many visits? _____

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes
Father's side	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐

Other: _____