PEDIATRIC HEALTH HISTORY FORM

Wihlidal Family Chiropractic 349 West St.N. Orillia, ON L3V 5E1

Name:_____ Date:_____
Address:_____ City:_____ Postal Code:_____
Parent Ph: (H)_____ (W)_____ Sex: M F Birthdate:_____
Parents and Siblings Names:_____
Parents Email_____
Who may we thank for referring you?_____

THE PURPOSE OF THIS FORM

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

#1 Current Health Concern (if there are no current symptoms and this assessment is to ensure optimum health and functioning, skip to section 2)
Health Concern:_____
When did it begin?_____ How often does it occur?_____
What relieves?_____ What aggravates?_____
Other professionals seen for concern_____
Treatment and results_____

#2 Birth History
Child's gestational age at birth ___ weeks Birth weight _____ length_____
Birth experience? Midwife or Medical Labour? Spontaneous or Induced
Any procedures during birth? **Forceps/Vacuum Extraction/C-section/Episiotomy**
Any complications before or after birth? Please explain _____
_____
Evidence of obvious birth trauma? Bruising ___ Odd shaped head ___
Stuck in birth canal ___ Cord around neck ___

#3 Family Health History
Please note any health issues that are present with family relations
Brothers_____ Sisters_____
Mother_____ Father_____
Grandparents_____

(Please complete other side)

In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxation**. **Subluxations** are areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. **Subluxations** are caused by physical, chemical and mental/emotional stresses that overwhelm the nervous system and spine. Please answer the following questions to the best of your ability. This will help us to determine the causes of the **subluxations** we may find.

PHYSICAL STRESSES

Any significant falls or trauma to the mother during pregnancy? **Yes No Unsure**
For the child, were there any falls from couches, beds, change tables, etc.? **Yes No Unsure**
Any hospital visits for concussions, possible fractures or other traumas? **Yes No Unsure**
Have there been any surgeries? **Yes No** If yes, please explain_____
Is a backpack worn? **Yes No** Is it **light** or **heavy**?
Does your child participate in sports? **Yes No** If yes, which ones?_____
Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e./violin, gymnastics, etc.)
Yes No Unsure

CHEMICAL STRESSES

During pregnancy, did the mother: use medications? **Yes No** If yes, which ones?_____
smoke? **Yes No**
drink? **Yes No**
Was the child breast-fed? **Yes No** If yes, how long?_____
Formula introduced at what age? _____
Began solid foods at what age? _____
Vaccination history: Vaccinations given _____
Any reactions? **Yes No** _____
Has the child been or is the child currently on any medications? **Yes No** If yes, please list_____
_____

MENTAL/EMOTIONAL STRESSES

Any problems with bonding? **Yes No Unsure**
Any behavioural problems? **Yes No Unsure**
Any night terrors, sleep walking, difficulty sleeping? **Yes No**
Average number of television hours per week? _____
Do you feel that you child's social and emotional development is appropriate for their age? **Yes No Unsure**

Thank you for completing this form. If you have any further concerns, please note them in the space below.

Authorization For Care of a Minor (Under 16 years of age)

Parent(s) Name(s)_____ hereby consent to the chiropractic assessment and care for our child at the Wihlidal Family Chiropractic Centre.
Parent Signature _____ Date:_____ Witness Signature _____