CHILDREN'S HISTORY FORM

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know, and we would be happy to assist.

Name:_____Date:_____
Address: _____City: _____ Prov: ____ PC: _____
Phone Number (H): _____ (W): _____
Email Address: _____
Date of Birth: _____ Referred By: _____
Mother's Name: _____ Father's Name: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No
If Yes: When: _____ From who: _____
Name of Family Medical Doctor: _____
Present Length/Height: _____ Weight: _____
Care Card Number (AHC): _____ M F

What is the Major Reason for Consulting our Office?
☐ Injury/Accident ☐ Recurring/Chronic Problem ☐ Check Up/Wellness

Please Explain: _____
_____
Is this related to: ☐ sports ☐ auto ☐ fall ☐ home injury ☐ other
Please Explain: _____
_____

List Other Care Undergone for this Complaint:
(including medications) _____
Date of Onset: _____ Onset was: Sudden / Gradual / Injury
Duration of Problem / episode: _____ minutes / hours / days / months / years
Pattern of Problem: Constant / Intermittent / Occasional / Cyclical
Initiating / Aggravating Factors: _____
Relieving Factors: _____
Effects of problem on body function and daily activities: _____
_____
Prior Occurrence or Episodes: _____

Child's Health History:
Please check each of the diseases or conditions that the child has had in the past

☐ Vision problems	☐ Pink eye	☐ Headaches
☐ Ear problems	☐ Tubes in the ears	☐ Sleeping disorders
☐ Skin problems	☐ Frequent colds	☐ Allergies
☐ Irritability	☐ Attention problems	☐ Colic
☐ Breathing problems	☐ Digestive problems	☐ Constipation
☐ Asthma	☐ Bed Wetting	☐ Sinus/congestion
☐ Hyperactivity	☐ Tonsil or adenoid problems	

Other Health Concerns: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

History of Birth:

Delivery was at: hospital / birthing center / home / medical / midwife
Duration of gestation: _____ weeks
Assisted birth: ☐ Yes ☐ No If Yes: forceps / vacuum extraction / c-section / induced labour
Any medications delivered to mother at birth? ☐ Yes ☐ No If Yes, what?_____
Any complications at birth? ☐ Yes ☐ No
Birth Weight: _____ Length: _____
Were any of the following experienced immediately after birth?
☐ jaundice ☐ feeding problems ☐ respiratory problems ☐ displaced or broken joints

Growth and Development:

At birth, was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No
Explain _____
Do sleeping patterns seem normal to you? ☐ Yes ☐ No
Please explain:_____
Any health problems on either side of the family?
☐ cancer ☐ diabetes ☐ heart disease ☐ stroke ☐ high blood pressure
☐ arthritis ☐ other:_____

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

Chemical Stressors:

Was this child breast fed as a baby? ☐ Yes ☐ No How long? _____
Have you noticed any food allergies? ☐ Yes ☐ No Please explain _____
During the pregnancy did the mother smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No
Any drugs taken during the pregnancy? ☐ Yes ☐ No
Has the child had any vaccinations or antibiotics? ☐ Yes ☐ No
What vaccinations have been received?
☐ DPT ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis
☐ Other: _____

Psychosocial Stressors:
Any problems with: lactation / bonding / behavioural problems?
Any night terrors, sleep walking, difficulty sleeping? _____
Age when child began daycare: _____
Average hours of television / week: _____
Does your child seem normal for their age? ☐ Yes ☐ No Please explain: _____
_____

Traumatic Stressors:
Any trauma during pregnancy? (falls, accidents) _____
Any evidence of birth trauma? (bruises, cord around neck, odd shaped head, stuck in birth canal, fast or long birth, etc.) _____
Any falls or accidents? (change tables, couches, beds, car accident)_____
_____
Any trauma with bruising, cuts, stitches, fractures? _____
Any hospitalizations? ☐ Yes ☐ No Please explain: _____
Any surgeries or organs removed? _____
Sports played: _____

Goals for Care:
We have practice members start care with us for a variety of reasons. Some want pain relief, some come to correct the cause of pain, and others come to establish strategies to handle the tension and stress that develops in their bodies. Please indicate below the type of care you desire for your child and this may affect the treatment program recommended to you.

☐ Pain Relief
☐ Corrective Care (includes relieving cause of problem and symptoms)
☐ Wellness Care / Levels of NSA

What do you hope to achieve by receiving care at our office?_____
_____

Your signature will verify that this information is correct.

_____ _____
Parent's Signature Date

Thank you for completing this form!