

# Child History Form

*Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.*

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Sibling(s) Name(s) (Ages): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov. \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Bus Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F Referred by: \_\_\_\_\_

Do you have Blue Cross coverage for your child? \_\_\_\_\_

Has your child ever received chiropractic care?  Yes  No If yes, previous DC's name and last visit date?

\_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_

Date of last MD visit and reason: \_\_\_\_\_

## **AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)**

PARENT(S) NAME(S): \_\_\_\_\_ WORK TEL: \_\_\_\_\_

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

## **Present Health Complaints/Concerns:**

Major: \_\_\_\_\_

\_\_\_\_\_

Minor: \_\_\_\_\_

\_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Is this problem:  Occasional  Frequent  Constant  Intermittent

Does problem radiate?  Yes  No If yes, where? \_\_\_\_\_

What makes this worse? \_\_\_\_\_

What makes this better? \_\_\_\_\_

Is the problem worse during a certain time of the day?  Yes  No If yes, when? \_\_\_\_\_

Does this interfere with the child's  Sleep?  Eating?  Daily Routine?

Is this becoming worse? \_\_\_\_\_

Other professionals seen for this condition? \_\_\_\_\_

Results with that treatment? \_\_\_\_\_

\_\_\_\_\_

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Loss Of Taste        | <input type="checkbox"/> Weight Gain           | <input type="checkbox"/> Upper Back Pain     |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Light Sensitivity    | <input type="checkbox"/> Dental Problems       | <input type="checkbox"/> Neck Pain           |
| <input type="checkbox"/> Fainting              | <input type="checkbox"/> Face Flushed         | <input type="checkbox"/> Fevers                | <input type="checkbox"/> Low Back Pain       |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Cold Sweats          | <input type="checkbox"/> Heart Palpitations    | <input type="checkbox"/> Radiating Pain      |
| <input type="checkbox"/> Irritability          | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Chest Pressure        | <input type="checkbox"/> Stiffness           |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Breast Pain           | <input type="checkbox"/> Reduced Mobility    |
| <input type="checkbox"/> Loss Of Balance       | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Frequent Colds        | <input type="checkbox"/> Numbness In Leg(s)  |
| <input type="checkbox"/> Loss Of Concentration | <input type="checkbox"/> Shortness Of Breath  | <input type="checkbox"/> Sinus Congestion      | <input type="checkbox"/> Numbness In Feet    |
| <input type="checkbox"/> Loss Of Memory        | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Sore Throats          | <input type="checkbox"/> Numbness In Hand(s) |
| <input type="checkbox"/> Ears Buzzing          | <input type="checkbox"/> Urinary Problems     | <input type="checkbox"/> Ear Pain / Infections | <input type="checkbox"/> Weakness            |
| <input type="checkbox"/> Poor Coordination     | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Muscle Cramps       |
| <input type="checkbox"/> Vision Changes        | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Loss Of Smell         | <input type="checkbox"/> Weight Loss          | <input type="checkbox"/> Bloating / Gas        |  |
| <input type="checkbox"/> Other: _____          |   |  |  |

## History of Birth

What was the child's gestational age at birth? \_\_\_\_\_ Weeks.

Birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz. \_\_\_\_\_ Birth length \_\_\_\_\_ inches

Was your child's birth  at home  in a birthing center  in a hospital

Was the birth considered  medical  midwife

What was the duration of the labour and birth? \_\_\_\_\_ hours

Was child born  Cephalic (head first)  Breech (feet first)

Were there any complications?  Yes  No If yes, please explain \_\_\_\_\_

Please check any assistance which was used during the birth:

- Forceps  Vacuum Extraction  C-Section  Episiotomy

Was labour  Spontaneous  Induced

Were medications or epidurals given to the mother during birth?  Yes  No If yes, what was given? \_\_\_\_\_

APGAR score: at Birth \_\_\_\_\_ /10 After 5 minutes \_\_\_\_\_ /10

## Growth and Development

Was the infant alert and responsive within 12 hours of delivery?  Yes  No If no, please explain \_\_\_\_\_

At what age did the child: Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold up head \_\_\_\_\_ Vocalize \_\_\_\_\_  
Sit alone \_\_\_\_\_ Teeth \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Do you consider the child's sleeping pattern normal?  Yes  No If no, please explain \_\_\_\_\_

## Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family \_\_\_\_\_

Father's family \_\_\_\_\_

Sibling(s) \_\_\_\_\_

**Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.**

## Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.)  Yes  No If yes, please explain \_\_\_\_\_

Any evidence of birth trauma to the infant?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bruising                       | <input type="checkbox"/> Odd Shaped Head        | <input type="checkbox"/> Stuck In Birth Canal |
| <input type="checkbox"/> Fast Or Excessively Long Birth | <input type="checkbox"/> Respiratory Depression | <input type="checkbox"/> Cord Around Neck     |

Any falls from couches, beds, change tables, etc?  Yes  No If yes, please explain \_\_\_\_\_

Any traumas resulting in bruises, cuts, stitches, or fractures?  Yes  No If yes, please explain \_\_\_\_\_

Any hospitalizations or surgeries?  Yes  No If yes, please explain \_\_\_\_\_

Any sports played? \_\_\_\_\_

Is a school backpack used?  Yes  No If yes, is it  Heavy  Light

## Chemical Stressors

Was this child breast-fed?  Yes  No If yes, how long? \_\_\_\_\_

Formula introduced at what age? \_\_\_\_\_ What formula? \_\_\_\_\_

Introduction of cow's milk at what age? \_\_\_\_\_

Began solid foods at what age? \_\_\_\_\_ Type of foods? \_\_\_\_\_

Food / Juice intolerance?  Yes  No If yes, what type? \_\_\_\_\_

During pregnancy, did the mother, smoke?  Yes  No How much? \_\_\_\_\_

drink?  Yes  No How much? \_\_\_\_\_

Any illnesses during the pregnancy?  Yes  No If yes, what illnesses? \_\_\_\_\_

Any supplements taken during pregnancy?  Yes  No If yes, what supplements? \_\_\_\_\_

Any drugs taken during pregnancy?  Yes  No If yes, what drugs? \_\_\_\_\_

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Any ultrasounds?  Yes  No How many and reasons for being done? \_\_\_\_\_

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)?  Yes  No Please explain \_\_\_\_\_

Any smokers in the home?  Yes  No

**Vaccination History**

Vaccinations and age given? \_\_\_\_\_

Any negative reactions?  Yes  No If yes, what were they? \_\_\_\_\_

Any antibiotics given?  Yes  No Reason? \_\_\_\_\_

**Psychosocial Stressors**

Any difficulties with lactation?  Yes  No If yes, what are they? \_\_\_\_\_

Any problems with bonding?  Yes  No If yes, what are they? \_\_\_\_\_

Any behavioural problems?  Yes  No If yes, what are they? \_\_\_\_\_

Any  night terrors  sleep walking  difficulty sleeping

Age of child when he/she began daycare? \_\_\_\_\_

Average number of hours of television per week? \_\_\_\_\_

Do you feel that your child's social and emotional development is normal for their age?  Yes  No If yes, how? \_\_\_\_\_

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.