

Child Health History Intake Form

Please complete the following to the best of your knowledge. If you require assistance, please ask the front desk staff and they will be glad to help.

Child's Name: _____ Date: _____

Parent(s) Name: _____

Sibling(s) Names/Ages: _____

Address: _____

Postal Code: _____ Home #: _____ Cell #: _____

Date of Birth: _____ Age: _____ Referred by: _____

Has your child ever received Chiropractic Care? Yes No Dr: _____

Name of Family Doctor: _____

Date of last visit to family doctor and reason: _____

<p style="text-align: center;">AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)</p> <p>Parent(s) name: _____ Cell # _____</p> <p>I hereby authorize and consent to the chiropractic evaluation of my child.</p> <p>Parent/Guardian</p>

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major: _____

Minor: _____

When did the problem begin: _____

Is the problem (circle): occasional frequent constant intermittent

Does the problem radiate? yes no

What makes this worse: _____

What makes this better: _____

Is the problem worse during a certain time of 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 treatment: _____

OFTEN SEEMINGLY UNRELATED, SYMPTOMS CAN MANIFEST AS OPTHER HEALTH CONCERNS. PLEASE TICK 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 legs
<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 hands
<input type="checkbox"/> ear buzzing	<input type="checkbox"/> urinary problems	<input type="checkbox"/> ear pain/infection	<input type="checkbox"/> weakness
<input type="checkbox"/> poor co-ordination	<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 (circle): at home in a birthing centre in a hospital
 Was the birth considered (circle): medical midwife
 What was the duration of the labor and birth? _____ hours
 Was the child born (circle): cephalic (head first) breech (feet first)
 Were there any complications? Yes No If yes, please explain

Please circle any assistance which was used during the birth
 Forceps Vacuum Extraction C-section Episiotomy

Was your labor (circle) 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

FAMILY HEALTH HISTORY

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
 Mother's family: _____
 Father's family: _____
 Siblings: _____

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

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy (ie: falls, accidents, etc.) yes no
 Please explain: _____

Any evidence of birth trauma to the infant (please tick)?
 bruising odd shaped head
 stuck in birth canal fast of excessively long birth
 respiratory depression cord around neck

Any falls from couches, beds, change tables, etc? Yes No

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 Is it(circle): heavy light

CHEMICAL STRESSORS

Was the child breast-fed? Yes No If so, how long? _____
Formula introduced at what age? _____
Introduction of cow's milk at what age? _____
Began solid foods at what age? _____ Type of foods: _____
Food/Juice intolerances? Yes No Type? _____

During pregnancy, did the mother
Smoke? Yes No How much? _____
Drink? Yes No How much? _____
Any illnesses during pregnancy? Yes No _____
Any supplements taken during pregnancy? Yes No _____
Any drugs taken during pregnancy? Yes No _____
Any ultrasounds? Yes No How many and reasons for being done? _____

Any invasive procedures during pregnancy (ie. amniocentesis, CVS, etc.)? Yes No
Please explain: _____
Any pets at home? Yes No
Any smokers at home? Yes No

Vaccination History

Vaccinations and age given? _____
Any negative reactions? Yes No
Any antibiotics given? Yes No

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? Yes No _____
Any problems with bonding? Yes No _____
Any behavioural problems? Yes No _____
Any night terrors, sleep walking, difficulty sleeping? Yes No _____
Age of child when 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

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.