

CONFIDENTIAL HEALTH HISTORY - CHILD

Child's Name: _____ Gender: M F D.O.B.: M / D / Y File No.: _____
 Parent(s) Name: _____ Sibling(s) Name(s) (Ages): _____
 Address: _____ City/Province: _____ PC _____
 Home Phone: _____ Email: _____
 Who may we thank for referring you to our office? _____

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, and I have been made aware of what the risks and benefits are for my child to receive chiropractic care.

PARENT/GUARDIAN SIGNATURE: _____ DATE: M / D / Y

WITNESS SIGNATURE: _____ NAME: _____

Has your child ever received chiropractic care? N Y Who? _____ Last visit: M / D / Y
 Name of Medical Doctor: _____ Location or Tel. Number? _____
 Date of last MD visit and reason: M / D / Y _____
 Current Weight: _____ Height: _____ Any recent weight: Loss Gain How much? _____

CURRENT HEALTH CONDITION

Current Health Complaint(s): _____
 When did this begin? _____
 Has the condition occurred before? Yes No When? _____
 Is the condition: School/Sport Related Auto Related Home Injury Fall Other: _____
 What does it feel like: Sharp Dull Ache Pins & Needles Numb Burning Other: _____
 Frequency of Pain: Constant Intermittent If intermittent, how often? _____
 How long does each episode last? _____ When was your last episode? _____
 Please circle a number below to indicate the severity of your pain:
 (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
 Has the condition been getting: Worse Better Stayed the Same
 What aggravates the condition? _____
 What makes the condition feel better? _____
 Does your pain radiate anywhere (e.g. into arms or legs)? Y N Where? _____
 What activities are you unable to do because of this condition? _____
 Have you had any previous injuries to the area of your complaint? Y N When? _____
 Have you seen another health professional for this condition? Y N Who? _____
 What previous treatments have you received for this condition? _____

Patient: _____

File No.: _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has currently or in the past 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"/> Bed Wetting |
| <input type="checkbox"/> Other: _____ | | | |

HISTORY OF BIRTH

What was the child's gestational age at birth? _____ Weeks. Birth weight: _____ Birth length: _____

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) Cesarean

Were there any complications? No Yes, please explain _____

Please check any assistance which was used during the birth: Forceps Vacuum Extraction

Was labour: Spontaneous Induced

Were medications or epidurals given to the mother during birth? No Yes, what was given? _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? Yes 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, please explain _____

Has your daughter begun menstruating? No Yes, when _____

Has your child experienced any other developmental delays/problems? No Yes, please explain: _____

HEALTH HISTORY

Patient: _____

File No.: _____

Please indicate if your child has had any surgeries/operations/hospitalizations:

- Appendix Tonsils Gall Bladder Hernia Back Surgery Broken Bones: _____
 Other: _____

Does your child have any medical conditions: _____

Is your child currently taking any medications or supplements: _____

Has your child had any of the following done in the last six months: X-ray Ultrasound MRI CT scan

Has your had any blood work done in the last year? Y N If yes, why? _____

Is there any member of your family who has the following:

- Diabetes Cancer Arthritis Stroke Neurological Disorder Blood Pressure Problem
 Heart Problem Seizures/Convulsions Similar Condition To Your Current Complaint

Vaccinations and age given? _____

Any negative reactions? No Yes, what were they? _____

Any antibiotics given? No Yes, reason? _____

PHYSICAL/CHEMICAL STRESSORS

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.

Any traumas to the mother during pregnancy? (E.g. Falls, accidents, etc.) No Yes: _____

Any evidence of birth trauma to the infant? No Yes: _____

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

Any sports played? _____

Is a school backpack used? No Yes, approximately how much does it weigh? _____

Was this child breast-fed? No 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 first introduced to? _____

Food / Juice intolerance? No Yes, what type? _____

During pregnancy, did the mother, smoke? No Yes, how much?
drink? No Yes, how much?

Any illnesses during the pregnancy? No Yes, what illnesses? _____

Any supplements taken during pregnancy? No Yes, what supplements? _____

Any drugs taken during pregnancy? No Yes, what drugs? _____

Any ultrasounds? No Yes, how many and reasons for being done? _____

Any invasive procedures during pregnancy (E.g. Amniocentesis, CVS, etc.)? No Yes: _____

Any pets at home? No Yes, what kind(s)? _____

Any smokers in the home? No Yes

Any difficulties with lactation? No Yes, what are they? _____

Any problems with bonding? No Yes, what are they? _____

Any behavioural problems? No 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? No Yes