

**CHILD HISTORY FORM?**

PRESENT DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PLEASE COMPLETE THIS DETAILED HISTORY FORM AND SUBMIT IT TO THE RECEPTIONIST. SHOULD YOU REQUIRE ANY ASSISTANCE, PLEASE LET US KNOW, AS WE WOULD BE HAPPY TO ASSIST.

NAME: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

EXTENDED HEALTH COVERAGE: YES / NO COMPANY: \_\_\_\_\_

Present Length: \_\_\_\_\_ Weight: \_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR**

PARENT(S) NAMES: \_\_\_\_\_ Work telephone: \_\_\_\_\_

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

Parent/Guardian signature: \_\_\_\_\_ Witness: \_\_\_\_\_

**CHIEF HEALTH CONCERNS**

REASONS FOR CONTACTING US: \_\_\_\_\_

**LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT**

(including medication): \_\_\_\_\_

Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset was: Sudden / Gradual / Associated with an event

Duration of problem (episode): \_\_\_\_\_ minutes / hours / days / months / years

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Initiating factors: \_\_\_\_\_

Aggravating factors: \_\_\_\_\_

Relieving factors: \_\_\_\_\_

Effects of problems on body function and daily activities: \_\_\_\_\_

Prior occurrence or episodes: \_\_\_\_\_

**OTHER HEALTH CONCERNS: \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF BIRTH**

Hospital: Birthing Center / Home / Medical / Midwife

Duration of Gestation \_\_\_\_\_ weeks

Assisted birth: No / Yes If yes: forceps / vacuum / extraction / c-section / induced labour

Medications delivered to mother at birth? No / Yes If Yes, what?: \_\_\_\_\_

Duration of birth: \_\_\_\_\_

Complications at birth: No / Yes Explain: \_\_\_\_\_

Was delivery normal? Yes / No \_\_\_\_\_

APGAR at BIRTH \_\_\_\_\_ AFTER 5 MINUTES \_\_\_\_\_

BIRTH WEIGHT \_\_\_\_\_ BIRTH LENGTH \_\_\_\_\_

**GROWTH & DEVELOPMENT:**

Was the infant alert and responsive within twelve hours of delivery? Yes / No

(Explain): \_\_\_\_\_

At what age did the child: Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_

Hold up head \_\_\_\_\_ Vocalize \_\_\_\_\_ Sit Alone \_\_\_\_\_

Teethe \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Do sleeping patterns seems normal to you: Yes / No Explain: \_\_\_\_\_

Any health problems(cancer, diabetes, heart disease, etc.) on the mother's side of the family \_\_\_\_\_

On the father's \_\_\_\_\_ With Siblings \_\_\_\_\_

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 baby breast-fed? No / Yes How long \_\_\_\_\_

Formula introduced at age: \_\_\_\_\_ Type of formula used: \_\_\_\_\_ Introduction of cow's milk at age: \_\_\_\_\_

Began solid foods at age: \_\_\_\_\_ Type: \_\_\_\_\_ Age & type of commercial baby food introduced: \_\_\_\_\_

Food / Juice intolerance No / Yes Type: \_\_\_\_\_

During pregnancy did the mother smoke? Yes / No

Did the mother drink alcohol? Yes / No

Any illness of the mother during pregnancy?: \_\_\_\_\_

Any supplements of mother during pregnancy?: \_\_\_\_\_

Any drugs taken during pregnancy: \_\_\_\_\_

Any exposures to ultrasound: No / Yes If so, how many and what was the medical reason?: \_\_\_\_\_

Any invasive procedure (amniocentesis, VCS): \_\_\_\_\_

Any pets at home: No / Yes: \_\_\_\_\_

Any smokers at home No / Yes (How much): \_\_\_\_\_

Any vaccinations: Which ones and any reactions: \_\_\_\_\_

Any antibiotics: No / Yes: Explain: \_\_\_\_\_

Total number of course of antibiotics to date: \_\_\_\_\_

**PSYCHOSOCIAL STRESSORS:**

Any difficulties with lactation? No / Yes \_\_\_\_\_

Any problems with bonding? No / Yes \_\_\_\_\_

Any behavioural problems? No / Yes Onset: \_\_\_\_\_

Any night terrors ,sleep walking, difficulty sleeping? No / Yes Specify: \_\_\_\_\_

Age of child when began daycare: \_\_\_\_\_

Average number of hours of television / week: \_\_\_\_\_

Does your child seem normal for their age? Yes / No Explain: \_\_\_\_\_

**TRAUMATIC STRESSORS:**

Any trauma during pregnancy (falls, accidents)? \_\_\_\_\_

Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other? \_\_\_\_\_

Any falls from coaches, beds, change tables? \_\_\_\_\_

Any traumas with bruising, cuts, stitches, fractures? \_\_\_\_\_

Any hospitalizations? No / Yes Explain: \_\_\_\_\_

Any surgeries or organs removed? \_\_\_\_\_

Sports played and age began: \_\_\_\_\_

Number of hours per week played: \_\_\_\_\_

Weight of school backpack: \_\_\_\_\_

Approx. hours spent at play per week: \_\_\_\_\_

Thank you for completing this form. Please write any other questions you have below.