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: __________

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? ____________________

____

© Chiropractic Excellence

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

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

☐ Other: ____________________

Has there been a change in your child's eating habits? ☐ Yes ☐ No
If yes, please describe:____________________

Has there been a change in your child's sleeping habits? ☐ Yes ☐ No
If yes, please describe:____________________

Has there been a change in your child's disposition? ☐ Yes ☐ No
If yes, please describe:____________________

Does your child cry if a parent attempts to change its sleeping position? ☐ Yes ☐ No

Does your child wake up crying frequently at night? ☐ Yes ☐ No

Are there any other alterations of your child's normal sleep pattern? ☐ Yes ☐ No
If yes, please describe:____________________

Does your child have a fever of unknown origin? ☐ Yes ☐ No

Does your child have a loss of appetite or other recent eating disorder? ☐ Yes ☐ No
If yes, please describe:____________________

Does your child have a recent change in "bathroom" habits? ☐ Yes ☐ No
If yes, please describe:____________________

Has your child recently become irritable, restless, or grumpy? ☐ Yes ☐ No
If yes, please describe:____________________

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) ____

In this office we will perform a thorough assessment of your child's spine to locate areas of Vertebral Subluxations. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stressors

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

© Chiropractic Excellence

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal
☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ 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? ______________________________
____

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 pets at home? ☐ Yes ☐ No If yes, what kind(s)? ______________________________

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? ______________________________________

© Chiropractic Excellence

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? ____

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because strokes sometimes cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

Dated this ____________ day of ______________________, 20 ______.

______________________________	______________________________
Patient Signature (Legal Guardian)	**Witness of Signature**
______________________________	______________________________
Print Name	**Print Name**

© Chiropractic Excellence