LaHave River Chiropractic & Health Centre

CHILD HISTORY FORM

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

Child's Name: _____ Date:_____

Parent(s) Name(s): _____

Address: _____ City: _____ Prov.:_____ Postal Code: _____

Child's Date of Birth: _____ Age: _____ Gender: _____ Referred By: _____

Sibling(s) Name(s), Age(s) _____

Health Card Number: _____

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

_____

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 chiropratic evaluation of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

Present Health Complaints / Concerns:

Please complete as appropriate; if there are no complaints / concerns please go to next page.

Major:_____

_____

Minor:_____

_____

When did this problem begin?_____

Is this problem: ❒ Occasional ❒ Frequent ❒ Constant ❒ Intermittent

Does the problem radiate? ❒ No ❒ Yes If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse at a certain time of the day? ❒ No ❒ Yes 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? _____

HISTORY OF PREGNANCY

Any Traumas to the mother during pregnancy? (e.g. falls, accidents, etc.) ❒ No ❒ Yes If yes, please explain.

_____

_____

Any Ultrasounds? ❒ No ❒ Yes How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (e.g. Amniocentesis, CVS, etc.)? ❒ No ❒ Yes

Please explain _____

During pregnancy, did the mother: Smoke ❒ No ❒ Yes How much? _____

Drink ❒ No ❒ Yes How much? _____

Any illnesses during the pregnancy? ❒ No ❒ Yes If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ❒ No ❒ Yes If yes, what supplements? _____

_____

Any drugs taken during pregnancy? ❒ No ❒ Yes If yes, what drugs? _____

_____

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 centre ❒ in a hospital

Was the birth considered: ❒ medical ❒ midwife

What was the duration of labor and birth? _____ hours

Was the child born: ❒ cephalic (head first) ❒ breech (feet first)

_____

Were there any complications? ❒ No ❒ Yes If yes, please explain _____

_____

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

Was the infant alert and responsive within 12 hours of delivery? ❒ No ❒ Yes If no, please explain_____

GROWTH & DEVELOPMENT HISTORY

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

Mother's family _____

Father's family_____

Siblings _____

Was this child breast-fed? ❒ No ❒ Yes If yes, how long?_____

Formula introduced at what age? _____ What formula?_____

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

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

Any behavioral problems? ❒ No ❒ Yes If yes, what are they?_____

_____

Any?: ❒ night terrors ❒ sleep walking ❒ difficulty sleeping

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

Any smokers in the home? ❒ No ❒ Yes

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 abnormal for his/her age? ❒ No ❒ Yes If yes, how?

_____

Do you consider the child's sleeping pattern normal?_____

VACCINATION HISTORY

Vaccinations and age give?_____

Any Negative reactions? ❒ No ❒ Yes If yes, what were they?_____

Any antibiotics given? ❒ No ❒ Yes Reason? _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS:

Please check if your child has any of the following:

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

Comments _____