

Child History Form

(Ages 6-12)

The data on this form is essential if we are to render the best professional care. We appreciate your cooperation in filling it out so that we will have accurate records.

Personal Information

Date:		
Patient's Last Name:	First Name:	Home Phone:
Home Address:	City/Town:	Postal Code:
Date of Birth (DD/MM/YYYY)	Age:	Male/Female
Legal Guardian:	Home Phone:	Alternate Phone:
Names and Ages of Siblings:		By whom were you referred?

APPOINTMENT REMINDER INFO (FILL OUT IF YOU ARE INTERESTED IN RECEIVING APPT REMINDERS)

Reminder type: Text Email

Cell number/email address: _____

Cell service Provider: _____

Would you like to receive a reminder:

Morning of appt Day before appt

*** Please note these reminders are not a replacement for marking your appointments down, they are a courtesy.*

Provincial Health Care Plan

Alberta Health Care Number: _____

Present MD and Clinic Name: _____

Date of last visit and reason: _____

Previous Chiropractor's name and last visit date: _____

Authorization for care of a minor:

Parent's name(s): _____

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

Parent/Guardian signature: _____

Witness: _____

Chief Health Concerns:

Please choose your purpose for seeking chiropractic care for your child:

- crisis management
 early detection of problems
 prevention
 wellness
 maximizing growth and development
 other: _____

List other care undergone for this complaint (including medications, recent tests, professionals seen)

Date of onset (DD/MM/YYYY): _____

Onset was: sudden/ gradual/ associated with an event

How long has the child had this condition? _____ minutes/hours/days/months/years

Has the problem been: consistent/ intermittent/ occasional/ cyclical

Does your child seem to be in pain? Yes No Describe: _____

What activities aggravate the child's condition?

What makes it feel better?

What are the side effects of this problem on the body's function and daily activities?

Does it interfere with the child's; Sleep? Y/N Eating? Y/N Daily Routine? Y/N

Has it been getting worse? Y/N

Prior occurrences or episodes?

Any other health concerns:

Birth History

Was your child's birth: at home in a birthing center hospital other

Duration of birth: _____ hours

Were there any complications? Yes No

If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labour: spontaneous induced

Is there anything else we need to know about the birth Yes No

If yes, please explain: _____

Often seemingly unrelated symptoms can manifest as other health concerns.

Please check off if your child has experienced any of the following in the past 6 months:

Musculo-Skeletal

- Ankle pain
- Knee pain
- Low back pain
- Pain between shoulders
- Neck pain
- Shoulder pain
- Elbow pain
- Difficult chewing/clicking jaw
- Reduced mobility

Nervous System

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold/tingling extremities
- Irritability
- Loss of balance
- Loss of concentration
- Poor coordination
- Loss of smell
- Loss of taste

C-V-R

- Chest pain/pressure
- Short breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems/congestion/asthma
- Bronchitis
- Pneumonia

General Code

- Fatigue
- Allergies
- Loss of sleep
- Fever
- Headaches

Gastro-Intestinal

- Poor/excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Weight changes
- Abdominal cramps
- Gas/bloating after meals
- Heartburn
- Black/bloody stool

Genito-Urinary

- Bladder trouble
- Painful/excessive urination
- Discolored urine

EENT

- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Hearing difficulty
- Stuffed nose
- Ears buzzing
- Frequent colds

Growth & Development

Were any of the following developmental markers delayed for your child?:

- Respond to sound _____ Follow an object _____
- Hold up head _____ Vocalize _____
- Sit alone _____ Teethe _____
- Crawl _____ Walk _____

Did all of these appear normal? Yes No Explain: _____

How does your child sleep?: Front Back Side

Do you consider the child’s sleeping pattern normal? Yes No How many hours per day? _____

If no, please explain _____

Family Health History

Please note any health problems (cancer, hereditary conditions, diabetes, heart disease) 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 also very important to us.

Physical Stressors

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

If yes, please explain _____

Any use of jolly jumpers, bumbo chairs etc.? Y N Explain: _____

Any traumas resulting in 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: heavy or light?

Chemical Stressors

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

Formula introduced at what age: _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child on or have taken any medications? _____

Any pets at home? Yes No _____

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

Is your child vaccinated as per Alberta guidelines? Yes No

Any reactions? _____

Do you and/or your child get the flu shot? Yes No Reactions? _____

Is the child's diet organic? Yes No

Do you use 'green products' in your home for cleaning? Yes No

How often does your child receive processed foods, white sugar, gluten (flour), dairy in their diet?

- Never On weekends A few times per week Daily Nearly each meal
 On special occasions

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No

Psychosocial Stressors

Any behavioral problems? Yes No _____

Any inattention? Yes No _____

Any hyperactivity or restlessness? Yes No _____

Any compulsiveness? Yes No _____

Any difficulties at daycare or school? Yes No _____

Any challenges with learning deficiencies? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Any prolonged temper tantrums or separation anxiety? Yes No _____

Is there stress in the household? Mild / moderate / high

Are the parents living together? _____

Do the parents work shift work? Out of town? Explain: _____

Is the child in day care Yes No _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work Yes No

Is the child home schooled? Yes No By whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No

How often do they text or use the phone? _____

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 you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.
