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 & Occupation:	Home Phone:	Alternate Phone:
Names and Ages of Siblings:		By whom were you referred?
Email Address (used for receipts)		

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/YYY): _____

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: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

UNDERLINE ANY CONDITIONS THAT ARE **PRESENTLY** CAUSING YOU A PROBLEM, **CHECK** ANY CONDITIONS WITHIN THE **LAST 6 MONTHS**:

GENERAL SYMPTOMS

- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Sleep Disturbance
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss
- ☐ Weight Gain

RESPIRATORY

- ☐ Chronic Cough
- ☐ Spitting Up Phlegm
- ☐ Spitting Up Blood
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Asthma

GENITOURINARY

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood In Urine
- ☐ Pus In Urine
- ☐ Kidney Infection
- ☐ Prostate Trouble
- ☐ Uncontrollable Urine Flow

NEUROLOGICAL

- ☐ Visual Disturbance
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Headache
- ☐ Numbness
- ☐ Neuralgia (Nerve Pain)
- ☐ Poor Coordination
- ☐ Weakness

CARDIOVASCULAR

- ☐ Rapid Beating Heart
- ☐ Slow Beating Heart
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain Over Heart
- ☐ Hardening Of Arteries
- ☐ Swollen Ankles
- ☐ Poor Circulation
- ☐ Palpitation
- ☐ Cold Hand or Feet
- ☐ Varicose Veins

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Difficult Digestion
- ☐ Heartburn
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood In Stool
- ☐ Gallbladder/Jaundice
- ☐ Colitis

EYES, EARS, NOSE, THROAT

- ☐ Eye Pain
- ☐ Double Vision
- ☐ Ringing In Ears
- ☐ Deafness
- ☐ Nosebleeds
- ☐ Trouble Swallowing
- ☐ Hoarseness
- ☐ Sinus Infection
- ☐ Nasal Drainage
- ☐ Enlarged Glands

MUSCLE & JOINT

- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Elbow Pain
- ☐ Hand Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Foot/Ankle Pain
- ☐ Pain/Numbness Down Arms or Legs
- ☐ Swollen Joints
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Fractures
- ☐ Difficult Chewing/Clicking Jaw

FOR WOMEN ONLY

- ☐ Painful Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Cramps Or Back Pain
- ☐ Vaginal Discharge
- ☐ Nipple Discharge
- ☐ Lumps In Breast
- ☐ Menopausal Symptoms
- ☐ Birth Control Pills
- ☐ Miscarriages
- ☐ Complications With Pregnancy
- ☐ Pregnant? Y / N Week?
- ☐ Other:

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, etc.? □ Yes □ No

If yes, please explain _____

Any use of jolly jumpers, bumbo chairs etc., as an infant? □ 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: _____

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

Where you given informed consent?□ 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 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 after school care □ Yes □ No_____

Age of child when began daycare? _____

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.

_____

_____

_____