

Pediatric Health History Form

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City: _____ Province: _____ Postal Code: _____

Parent's Home Phone: _____ Parent's Work Phone: _____

Health Card Number: _____

Parent's and Sibling's Names: _____

Who may we thank for referring you? _____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and our team will review it with you.

Current Health Concern

Health Concern: _____

When did it begin? _____ How often does it occur? _____

What relieves it? _____

What aggravates it? _____

Other Professionals Seen For Concern: _____

Treatment and Results: _____

Birth History

Child's gestational age at birth _____ weeks Birth Weight: _____ Length: _____

Birth experience: Midwife Medical Labour: Spontaneous Induced

Any procedures during birth? Forceps Vacuum Extraction C-section Episiotomy

Any complications before or after birth? Yes No

If yes, please explain: _____

Evidence of obvious birth trauma? Bruising Odd shaped head Stuck in birth canal Cord around neck

Family Health History

Please note any health issues that are present with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

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 Stresses

Any significant falls or trauma to the mother during pregnancy? Yes No Unsure
 For the child, were there any falls from couches, beds, change tables, etc? Yes No Unsure
 Any hospital visits for concussions, possible fractures or other traumas? Yes No Unsure
 Have there been any surgeries? Yes No
 If yes, please explain: _____
 Is a backpack worn? Yes No If yes, is it heavy or light?
 Does your child participate in sports? Yes No
 If yes, what sports: _____
 Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)
 Yes No Unsure

Chemical Stresses

During pregnancy, did the mother: – use medications? Yes No If yes, which ones? _____
 – smoke? Yes No
 – drink? Yes No
 Was the child breast-fed? Yes No If yes, how long? _____
 Formula introduced at what age? _____
 Began solid foods at what age? _____
 Vaccination history: Vaccinations given: _____
 Any reactions? Yes No If yes, please list: _____
 Has the child been or is the child currently on any medications? Yes No
 If yes, please list: _____

Mental/Emotional Stresses

Any problems with bonding? Yes No Unsure
 Any behavioural problems? Yes No Unsure
 Any night terrors, sleep walking, difficulty sleeping? Yes No Unsure
 Average number of television hours per week? _____
 Do you feel that your child's social and emotional development is appropriate for their age? Yes No Unsure

Authorization For Care of a Minor (Under 16 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic staff.

Child's Name: _____ Parent's Name: _____

Parent's Signature: _____ Date: _____

Thank you for completing this form. If you have any further concerns, please note them in the space below: