CHILD HISTORY FORM

THE DATA ON THIS FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR CO-OPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS.
PLEASE PRINT - THANK YOU

PERSONAL INFORMATION

DATE:			
PATIENTS LAST NAME	FIRST NAME		HOME PHONE
HOME ADDRESS	CITY/TOWN		POSTAL CODE
DATE OF BIRTH	DAY/MONTH/YEAR	AGE	MALE/FEMALE
LEGAL GUARDIAN	PHONE NO.	ALTERNATE EMERGENCY NAME & CONTACT	
BY WHOM WERE YOU REFERED			

PROVINCIAL HEALTH CARE INSURANCE PLAN

ALBERTA HEALTH CARE NUMBER	
OTHER HEALTH INSURANCE	PLAN/GROUP POLICY NUMBER

NAME OF FAMILY DOCTOR: _____

DATE OF LAST MD VISIT AND REASON: _____
_____

HAS THE CHILD HAD PREVIOUS CHIROPRACTIC CARE? YES NO

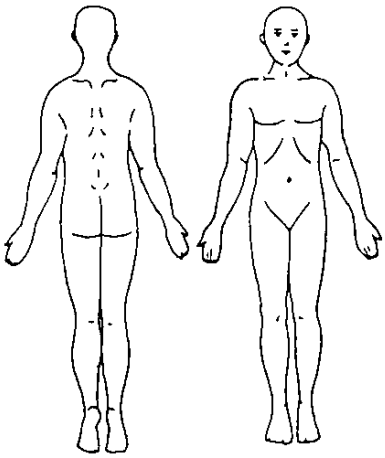
IF YES, NAME OF CHIROPRACTOR AND APPROXIMATE DATE OF LAST VISIT _____

PRESENT LENGTH _____ WEIGHT _____

PLEASE LIST ANY MEDICATIONS THAT THIS CHILD IS TAKING:
_____
_____
_____

ANY FAMILY HISTORY OF HEALTH CONCERNS? (CANCER, DIABETES, HEART DISEASE, ETC).
_____
_____
_____

Please outline on the diagram any areas of concern



CHIEF HEALTH CONCERNS:

REASON FOR CONTACTING US:

_____
_____
_____

DATE OF ONSET (D)_____/(M) _____/(Y) _____
ONSET WAS : SUDDEN/ GRADUAL/ ASSOCIATED WITH AN EVENT
HOW LONG HAS THE CHILD HAD THIS CONDITION ? ____ DAYS/ MONTHS/ YEARS
HAS THE PROBLEM BEEN: CONSTANT/ INTERMITTENT/ OCCASIONAL/ CYCLICAL
INDICATE THE PRESENT INTENSITY OF THE PAIN BY CIRCLING THE APPROPRIATE NUMBER:
(MILD) 1 2 3 4 5 6 7 8 9 10 (VERY INTENSE)

WHAT DOES THE PAIN FEEL LIKE: DULL/ ACHING/ BURNING/ THROBBING/ SHARP OTHER:
_____
WHAT ACTIVITIES AGGRAVATE THE CHILD'S CONDITION?
_____
WHAT MAKES IT FEEL BETTER ?
_____
WHAT ARE THE EFFECTS OF PROBLEMS ON THE BODY FUNCTION AND DAILY ACTIVITIES:
_____
_____

PRIOR OCCURRENCE OR EPISODES:
_____
_____

****

IF THIS CHILD IS 2 YEARS OR YOUNGER, PLEASE FILL OUT THE FOLLOWING PAGE

HISTORY OF BIRTH:
HOSPITAL: HOME: HOSPITAL: MIDWIFE:
DURATION OF GESTATION: _____ WEEKS
ASSISTED BIRTH: NO YES. IF YES: FORCEPS VACUUM EXTRACTION C-SECTION INDUCED
MEDICATIONS DELIVERED TO MOTHER AT BIRTH? NO YES. IF YES, WHAT?
DURATION OF BIRTH:
COMPLICATION AT BIRTH: NO YES. EXPLAIN _____

WAS DELIVERY NORMAL? YES NO INVASIVE PROCEDURES? _____
BIRTH WEIGHT _____ BIRTH LENGTH _____

GROWTH AND DEVELOPMENT:
AT WHAT AGE DID THE CHILD?:
RESPOND TO SOUND _____ FOLLOW AN OBJECT _____ HOLD UP HEAD _____
VOCALIZE _____ SIT ALONE _____ TEETHE _____
CRAWL _____ WALK _____
SLEEPING PATTERN SEEMS NORMAL TO YOU: YES NO (explain)

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

CHEMICAL STRESSORS:
WAS THIS BABY BREAST -FED? NO YES (how long)
FORMULA INTRODUCED AT AGE _____ TYPE OF FORMULA USED _____
INTRODUCTION OF COW'S MILD AT AGE _____
BEGAN SOLID FOODS AT AGE _____ TYPE _____
FOOD INTOLERANCE: NO YES . TYPE:
_____
DURING PREGNANCY DID THE MOTHER SMOKE? YES NO
DID THE MOTHER DRINK ALCOHOL? YES NO
ANY DRUGS TAKEN DURING PREGNANCY: _____
ANY PETS AT HOME: NO YES_____
ANY SMOKERS IN THE HOME: NO YES (how much?)
ANY REACTIONS TO VACCINATIONS: _____
_____
ANY ANTIBIOTICS: NO YES. Explain: _____

PSYCHOSOCIAL STRESSORS:
ANY DIFFICULTIES WITH LACTATION: NO YES
ANY BEHAVIORAL PROBLEMS: NO YES (Onset)
ANY NIGHT TERRORS, SLEEP WALKING, DIFFICULTY SLEEPING

TRAUMATIC STRESSORS:
ANY TRAUMAS DURING PREGNANCY ? (falls, accidents)
ANY EVIDENCE OF BIRTH TRAUMA: Bruises, Odd shaped head, Stuck in birth canal, Fast or excessively long birth, Respiratory depression, Cord around neck, Other

ANY TRAUMAS WITH BRUISING, CUTS, STITCHES, FRACTURES

ANY SURGERIES OR HOSPITALIZATIONS? YES NO _____