Barrhaven Family Chiropractic & Wellness Centre
Child History Form

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

Child's Name_______________________________________ Date______________
Parent(s) Name____
Siblings Names(Ages)____
Address_____________________________________ City___________ Prov. ____
Postal Code__________ Home Phone(____)_________ Bus Phone(____)_________
Date of Birth_____________________ Age______ Referred by _________________

Has your child ever received chiropractic care? ***Yes No***
If yes, previous DC's name and last visit date?_______________________________
Name of Medical Doctor ____
Date of last MD visit and reason ____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAMES ____________________________ WORK TEL __________
I hereby authorize and consent to the chiropractic evaluation of my child.
PARENT/GUARDIAN SIGNATURE______________________DATE_________
WITNESS SIGNATURE____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major____

Minor____

When did this problem begin?____

Is this problem (circle) ***occasional frequent constant intermittent***

Does problem radiate? ***Yes No*** If Yes, where? _______________________________

What makes this worse?____

What makes this better?____

Is the problem worse during a certain time of the day? ***Yes No***
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? ____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please tick if your child has had any of the following)

__ headaches	__ loss of taste	__ weight gain	__ upper back pain
__ dizziness	__ light sensitivity	__ dental problems	__ neck pain
__ fainting	__ face flushed	__ fevers	__ low back pain
__ fatigue	__ cold sweats	__ heart palpitations	__ radiating pain
__ irritability	__ bronchitis	__ chest pressure	__ stiffness
__ depression	__ pneumonia	__ breast pain	__ reduced mobility
__ loss of balance	__ difficulty breathing	__ frequent colds	__ numbness in leg(s)
__ loss of concentration	__ shortness of breath	__ sinus congestion	__ numbness in feet
__ loss of memory	__ asthma	__ sore throats	__ numbness in hand(s)
__ ears buzzing	__ urinary problems	__ ear pain/infections	__ weakness
__ poor coordination	__ constipation	__ allergies	__ muscle cramps
__ vision changes	__ diarrhea	__ heartburn	__ sleeping problems
__ loss of smell	__ weight loss	__ bloating/gas	

__ other: ____

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 center or in a hospital? (circle one)

Was the birth considered medical or midwife? (circle one)

What was the duration of the labour and birth? _____ hours

Was child born cephalic (head first) or breech (feet first)? (circle one)

Were there any complications? ***Yes No*** If Yes, please explain ________________________________
____

Please circle any assitance which was used during the birth

Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***

Was labour spontaneous or induced? (circle one)

Were medications or epidurals given to the mother during birth? ***Yes No***
If yes, what was given ____

APGAR score: at Birth ___/10 After 5 minutes___/10

GROWTH & DEVELOPMENT

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

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? Yes No
If no, please explain ____

FAMILY HEALTH HISTORY

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mothers family ____

Fathers 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 traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ***Yes No***
Please explain ____

Any evidence of birth trauma to the infant? (please tick)

__bruising ***__odd shaped head***
__stuck in birth canal ***__fast or excessively long birth***
__respiratory depression ***__cord around neck***

Any falls from couches, beds, change tables, etc? ***Yes No***
If yes, please explain ____

Any traumas resulting in bruises, cuts, 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? (circle one)

CHEMICAL STRESSORS

Was this child breast-fed? ***Yes No*** If yes, how long? ______________________________

Formula introduced at what age? __________ Which formula? ________________________

Introduction of cow's milk at what age? ____________

Began solid foods at what age? ___________ Type of foods? __________________________

Food/Juice intolerance? ***Yes No*** Type? ____

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During pregnancy, did the mother smoke? ***Yes No*** How much? _______

drink? ***Yes No*** How much? _______

Any illnesses during the pregnancy? ***Yes No*** ________________________________

Any supplements taken during pregnancy? ***Yes No*** ________________________

Any drugs taken during pregnancy? ***Yes No*** ____

Any ultrasounds? ***Yes No*** How many and reasons for being done? ____________________________
____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ***Yes No***
Please explain ____

Any pets at home? ***Yes No*** ____

Any smokers in the home? ***Yes No***

Vaccination history Vaccinations and age given? ____
____

Any negative reactions? ***Yes No*** ____
Any antibiotics given? ***Yes No*** Reason ____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ***Yes No***___________________________________

Any problems with bonding? ***Yes No*** ___________________________________

Any behavioural problems? ***Yes No*** ______________________________

Any night terrors, sleep walking, difficulty sleeping? ***Yes No*** ________________

Age of child when began daycare? __________

Average number of hours of television per week? ______________

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 there are any other questions or concerns which you have, you may write them in the space below.