



Children's Health History

It is our pleasure to welcome you to our family. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information.

Name: _____ Date: _____
 Address: _____ City: _____ Postal Code: _____
 Date of Birth: _____ Phone: _____
 Mother's / Guardian's Name _____ Work Phone: _____
 Father's / Guardian's Name _____ Work Phone: _____
 Who may we thank for referring you to our office? _____

Reason for contacting our office: _____
 Other Doctor's seen for this condition: No Yes, Doctor's Name: _____
 Please list treatments and results: _____
 Other health problems: _____
 Family health history: _____
 Previous Chiropractor: _____
 Date of last visit: _____ Reason: _____
 Name of Pediatrician: _____
 Date of last visit: _____ Reason: _____
 Number of doses of antibiotics your child has taken: _____
 Number of doses of other prescription medication your child has taken: _____
 Vaccination history: _____
 Vaccine reactions (please circle): high pitched screaming, non-stop crying, fever, rashes
 hives, convulsions, seizures, other: _____

PRENATAL HISTORY

Complications during pregnancy? No Yes, list: _____
 Complications during delivery? No Yes, list: _____
 Ultrasound during pregnancy? No Yes, when: _____
 Medications during pregnancy/delivery? No Yes, list: _____
 Location of birth? Hospital Birthing Centre Home
 Birth intervention? Caesarian section Vacuum extraction Forceps
 APGAR scores _____, _____ Cigarette/Alcohol use during pregnancy? Yes No
 Birth weight: _____ Birth Length: _____

FEEDING HISTORY

Breast-fed: No Yes, how long? _____ Introduced: solids at _____ months
Food sensitivities, allergies, intolerances: No Yes, list: _____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should be checked routinely by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what month was your child able to:

___ Cross crawl	___ Sit up
___ Respond to sound	___ Stand alone
___ Hold head up	___ Walk alone

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (ie. a bed, change table, down stairs). Was this the case with your child? No Yes, explain: _____

Is your child involved in any high impact or contact type sports? Yes No

Has your child been taught how to care for their spine? Yes No

Has your child been seen on an emergency basis? Yes No

Other traumas that were not listed above: _____

Prior surgery: No Yes, list: _____

Please indicate any conditions your child may have had, or currently has:

<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Rubella	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Behavioural Problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cough
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Eczema	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Backaches	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Headaches	<input type="checkbox"/> Allergies
<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic Earaches	<input type="checkbox"/> Mumps
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Leg Problems	<input type="checkbox"/> "Growing Pains"
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy/Seizure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Rubeola
<input type="checkbox"/> Constipation	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Convulsions

I hereby authorize this office and its doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Guardian's Signature: _____ **Date:** _____