Castlefield Chiropractic Child History Form

PARENTS: *Please print and complete as much as possible before arriving for your child(ren)'s checkup.*

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.