Child Health History Form

Child's Name:_______________________________________ Date:____________________

Parents/ Guardian Names:____

Address:____

City/ Postal Code:____

Parent's email address (for Patient Newsletter): ___________________________________

Child's Birth Date:_______________________________ Age:_____________ Sex: M F

How did you learn about our centre?____

Previous Chiropractic Care? Y N If so, when? ________________________________

Please check reasons for pursuing chiropractic care for your child:

_____ She/He is continuing care from another chiropractor.
_____ I recently had my spine checked and I see the value in getting my child checked.
_____ I'm concerned about her/his health and I'm looking for answers.
_____ She/He has a specific condition that concerns me. Explain condition or symptom: _______
____.
_____ I want to improve my child's immune system function.
_____ I have no idea why we're here. Please take the time to explain to me what you do for kids.

As a child or adolescent has or does your child experience any of the following?

_____ Headaches
_____ Allergies
_____ ADD/ADDH
_____ Growing/Back pains
_____ Sinus problems
_____ Learning disabilities
______ Postural imbalance
______ Ear infection
______ PDD/Autism
______ Digestive problems
______ Bedwetting
_____ Asthma
_____ Scoliosis
_____ Seizures
_____ Frequent colds
_____ Colic

Other:____
____.

List known allergies: ____.

List prescription or over the counter medications now taken: _______________________
____
____.

Number of doses of antibiotics your child has taken:
During the past 6 months: ______ During her/his lifetime: _______
List reasons:____.

Number of doses of other prescription medications taken:
During the past 6 months: ______ During her/his lifetime: _______
List reasons:____.

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Prenatal History:

Was your child adopted? N Y

Duration of gestation:________ weeks

Did you experience any complications during pregnancy? N Y List:____________________
____.

Ultrasounds during pregnancy? N Y Number:________________

Medications/drugs/caffeine during pregnancy? N Y List:____________________________

Cigarette/Alcohol use during pregnancy? N Y

Location of Birth: Hospital (name) ________ Home________

Did you use a midwife? ____________ doula? ____________ obstetrician?_____________

Birth Intervention:

Did you have a C-Section? ________

Vacuum Extraction? _________

Did you have an epidural? ________

Was the baby's skull/head mis-shapen? ________

Were forceps used? ________

Were you induced? ________

Was it a difficult birth? _________

Purple markings on face? ________________

Complications during delivery? N Y List:____

Was your child breastfed? N Y How long? _______________________

Was your child formula fed? N Y How long? _______________________

Food allergies or intolerances? N Y List: ____
____.

Were there any reactions to vaccinations? N Y List:______________________________
____.

As a baby/toddler/young child did any of the following occur?

_____ Fall from change table _____ Tumble down stairs _____ Fall out of crib

_____ Car accident _____ Fall from playground equipment _____ Play in 'jollyjumper'

_____ Fall from a tree _____ Fall off a bicycle _____ Sports accident

Has your child been involved in any contact sports? N Y List:_________________________.

Has your child been seen on an emergency basis? N Y List:____________________________.

Describe any hospital stays or surgeries: ____.

Is there anything else you feel we should know?
____
____

________________________________ ________________

Parent/ Guardian Signature Date

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