# PEDIATRIC HEALTH HISTORY

CHILD'S NAME GENDER DATE (DD/MM/YY)

AGE DATE OF BIRTH (DD/MM/YY)

PARENT NAMES

ADDRESS

TELEPHONE (HOME) TELEPHONE (OTHER)

FAMILY DOCTOR CLINIC NAME / ADDRESS

Who may we thank for referring you? ____________________

Has your child ever received chiropractic care? ❍ Yes ❍ No

IF YES, WHO IS YOUR CHILD'S PREVIOUS DOCTOR OF CHIROPRACTIC?

The date of last visit: ____________________

The reason for the last visit: ____________________

Other professionals seen for this condition: ____________________

Results with that treatment? ____________________

Recent tests done (list date beside): ❍ Blood work __________ ❍ Urine __________

❍ X-Rays __________ ❍ Other: explain __________

Please tick the purpose for your child's visit: ❍ Crisis management ❍ Early detection of problems ❍ Wellness

❍ Prevention ❍ Maximizing normal growth & development ❍ Other: __________

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## Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully!

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person. I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

NAME ______________________ DATE (DD/MM/YY) ______________________

SIGNATURE ______________________ WITNESS ______________________

DOCTOR OF CHIROPRACTIC ______________________

## Present health concerns

Primary reason for visit

______________________

______________________

Secondary reason for visit

______________________

______________________

When did this problem begin? ______________________

Is this problem: ❍ Occasional ❍ Frequent ❍ Constant ❍ Intermittent

What makes it better? ______________________ What makes it worse? ______________________

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

______________________

IF YES, WHEN?

Does this interfere with the child's sleep? ❍ Yes ❍ No

Appetite/Eating? ❍ Yes ❍ No Daily routine? ❍ Yes ❍ No Is this becoming worse? ❍ Yes ❍ No

# PEDIATRIC HEALTH HISTORY

**Often seemingly unrelated symptoms can manifest as other health concerns:**
(Please indicate if your child has had any of the following)

- ❍ Unexplained irritability
- ❍ Ear pain/infections
- ❍ Allergies
- ❍ Asthma
- ❍ Food allergies
- ❍ Constipation
- ❍ Diarrhea
- ❍ Gassiness
- ❍ Vomiting
- ❍ Chronic congestion
- ❍ Bed wetting
- ❍ Chronic colds/flu
- ❍ Fevers
- ❍ Dental issues
- ❍ Coordination difficulties
- ❍ Awkwardness of movement
- ❍ Difficulty swallowing
- ❍ Reflux
- ❍ Thrush
- ❍ Poor sleep
- ❍ Delayed crawling
- ❍ Delayed standing
- ❍ Delayed walking
- ❍ Delayed speech
- ❍ Poor hearing
- ❍ Poor visual tracking
- ❍ Other: ____________________

Was the birth: ❍ Cesearian section ❍ Vaginal birth Was child born: ❍ Cephalic (head first) ❍ Breech

Were there any complications? ❍ Yes ❍ No

Any illnesses during the pregnancy? ❍ Yes ❍ No

________________________________________

IF YES WHAT? WHAT MEDICAL ATTENTION WAS ADMINISTERED?

Any accidents or injuries during the pregnancy? ❍ Yes ❍ No

________________________________________

IF YES WHEN AND WHAT HAPPENED?

Any supplements taken during pregnancy? ❍ Yes ❍ No

________________________________________

IF YES WHAT WAS TAKEN? DOSAGE?

Any use of drugs taken during pregnancy? ❍ Yes ❍ No

________________________________________

IF YES WHAT? FOR HOW LONG? DOSAGE?

Did mother smoke during pregnancy? ❍ Yes ❍ No How much? ____________________

Did mother drink during pregnancy? ❍ Yes ❍ No

Was your child's birth: ❍ at home ❍ in a birthing center ❍ hospital ❍ other: ________________

Was labour: ❍ spontaneous ❍ induced

Were medications or epidurals given to the mother during birth? ❍ Yes ❍ No

Was there assistance of: ❍ vacuum ❍ forceps ❍ midwife ❍ doula

# PEDIATRIC HEALTH HISTORY

Duration of birth: ______________ hours

What was the child's gestational age at birth? ________________ weeks

Birth weight ______ lbs _____ oz

Birth length _______ inches

APGAR score at Birth ___________ /10

APGAR score at 5 minutes ________ /10

Did the child experience any of the following during or after their birth:

❍ Bruising ❍ Respiratory depression ❍ Fast or excessively long birth ❍ Stuck in birth canal
❍ Odd shaped head ❍ Cord around neck ❍ Jaundice

At what age did the child:

Respond to sound ____________ Roll over ____________________ Crawl ______________________

Hold up head ______________ Sit alone ____________________ Walk ______________________

How well does your child tolerate tummy time?

______________________________________________

FOR HOW LONG?

Does your child sleep: ❍ Front ❍ Back ❍ Side Is their mattress elevated? ❍ Yes ❍ No

Do you consider the child's sleeping pattern normal?

______________________________________________

IF NO, PLEASE EXPLAIN

Any falls from couches, beds, change tables, down stairs 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

Is this child breast-fed? ❍ Yes ❍ No

______________________________________________

IF NO, WHAT FORMULA ARE THEY EATING? WHAT AGE WAS IT INTRODUCED?

Any difficulties with nursing? ❍ Yes ❍ No ______________________________

# PEDIATRIC HEALTH HISTORY

Does the child favour one breast over the other? ❍ Yes ❍ No ______________________

Is the child tongue or lip tied? ❍ Yes ❍ No Lip tied? ❍ Yes ❍ No

Introduction of cow's milk at what age: __________ Began solid foods at what age: __________

Types of solid foods: ______________________

Food/Juice intolerance? ❍ Yes ❍ No Types: ______________________

Is your child on or have taken any medications? ❍ Yes ❍ No

IF YES WHAT ARE THEY TAKING? FOR HOW LONG? WHAT ARE THE DOSAGES?

Any ultrasounds? ❍ Yes ❍ No How many: ______________________

Reasons for being done: ❍ Yes ❍ No ______________________

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? ❍ Yes ❍ No

IF YES, PLEASE EXPLAIN

Any hyperactivity or restlessness? ❍ Yes ❍ No

Any prolonged temper tantrums or separation anxiety? ❍ Yes ❍ No

Is the child in day care? ❍ Yes ❍ No

Age of child when began daycare?

**Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.**