Infant & Child Health History Form

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Child's Name: _____ Sex: M F Date (dd/mm/yyyy): ____/_____/_____

Age: _____ Birth date (dd/mm/yyyy): ____/_____/_____ Parent(s') Name(s): _____

Address: _____ City: _____ Postal Code: _____

Phone: (home)_____ (work)_____ (cell)_____ Email: _____

Medical doctor's name and address: _____ Date of last appointment: _____

Previous chiropractor's name and address: _____ Date of last appointment: _____

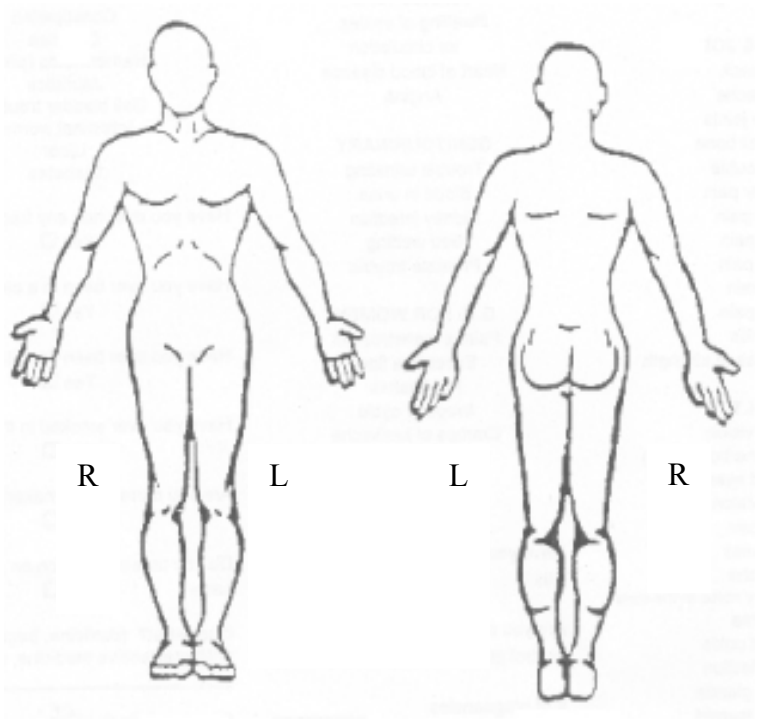
Who may we thank for referring you? / How did you hear about the office? _____

WHY THIS FORM IS IMPORTANT **In this office our focus is on assisting people to function optimally in order for them to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your child's physical, emotional and chemical stresses that can gradually overwhelm the body and contribute to health problems.**

#1 Current Health Concern(s): (*If there are no current concerns and this assessment is to ensure optimum health and functioning of your child, please skip to section #2.)*

Please mark the area(s) on your body that are causing you **pain** or **unusual sensation(s)** with the appropriate symbols.

Numbness	NNNNN NNNNN NNNNN
Burning	XXXXX XXXXX XXXXX XXXXX
Dull & Aching	DDDDD DDDDD DDDDD DDDDD
Pins & Needles	•••••• •••••• •••••• ••••••
Sharp & Stabbing	SSSSSS SSSSSS SSSSSS SSSSSS
Tight & Stiff	TTTTT TTTTT TTTTT TTTTT



FRONT BACK

Location of major complaint: _____ When did it begin? _____

Rank the level of discomfort (1 = minimal to 10 = extreme): _____ /10

Is it getting *(circle)*: worse better constant

How often does it occur? _____ What relieves it? _____

Does it cause problems somewhere else? _____ What aggravates it? _____

Any associated or related concerns? _____ Other professionals seen for this? _____

(OVER)

#2 Physical Stresses:

List all significant **injuries** and **traumas**: _____

List all **hospital visits** and approximate **dates**: _____

#3 Chemical Stresses:

List any current prescriptions or over-the-counter **medications**: _____

List any **supplements** (vitamins / minerals / herbs etc.): _____

Is your child exposed to **second hand smoke** on a regular basis *(circle)*? **No Yes**

Has your child been **vaccinated** *(circle)*? **No Yes** If yes, please list the **vaccinations** and any **side effects**:

_____

How is / was the child **fed** as an infant *(circle)*? **Breast** fed (until the age of: _____) **Formula** fed

How would you rate your child's **diet** *(circle)*? **Excellent Good Poor**

If breast fed, does / did the child have a **side of preference** *(circle)*? **No Left Right**

#4 Mental/Emotional Stresses:

Psychological stress has been shown to negatively affect the function of the nervous system. On a scale of 1 to 10 please rank your child's **overall mental / emotional stress level** (1 = minimal to 10 = extreme): ____ / 10

#5 General Health History:

Weight at birth: _____ Current Weight: _____Length at birth: _____Current Length/Height: _____

APGAR Score: ____/10 Reason(s) for loss of points: _____

Pregnancy:

Length: _____ weeks _____ days **Weight gain** during pregnancy: _____ lbs

Medications / Drugs taken during pregnancy: _____

Vitamin / Supplements taken during pregnancy: _____

Was **ultrasound** performed? **Yes No** If yes, list the **number** and **reason(s)**: _____

Was **amniocentesis** performed? **Yes No** If yes, list the **reason(s)** and **result(s)**: _____

Illnesses during pregnancy *(circle all that apply)*:

Elevated blood pressure	Toxicity	Gestational diabetes
Infections	Bleeding	Other: _____

Labour & Delivery:

Length of hard labour: _____ hours

Medical Intervention *(circle all that apply):*

Chemically induced labour	Epidural or other anesthetic	Caesarian Section
Forceps	Vacuum extraction	Other: _____

Postnatal:

Number of **wet** diapers per day? _____ Number of **soiled** diapers per day? _____

When did the following **milestones** occur, if applicable?

Lifts head:	_____	Sits independently:	_____
Smiles:	_____	Crawls:	_____
Rolls over:	_____	Stands independently:	_____
Reaches for objects:	_____	Walks:	_____
Imitates sounds:	_____	Talks:	_____

List any past or present **health condition(s)** or **disease(s)**: _____

Does your child have a **significant history** or **recent experiences** of any the following *(please **circle** all that apply)?*

Colic	Loss of weight	Headaches	Indigestion / Heartburn	Clumsiness
Sleeping problems	Night sweats	Eye problems	Ulcers	Dizziness / Fainting
Feeding problems	Fever	Loss of smell / taste	Heart problems	Loss of consciousness
Excessive spitting up	Infections	Sinus problems	Nausea / Vomiting	Attention problems
Frequent choking	Allergies	Recurrent ear infections	Fatigue / Weakness	Learning problems
Jaundice	Asthma/Breathing problems	Hearing problems	Scoliosis	Anxiety / Depression
Constipation / Diarrhea	Pneumonia / Bronchitis	Bladder problems	Frequent colds / illnesses	Physical / Mental Abuse
Congenital abnormalities	Tonsillitis	Bed Wetting	Loss of balance	Other:_____

Has your child ever had any **X-rays / CT scans / MRIs**? **Yes** **No** (if yes, **body part** and **year?**)_____

#6 Family Health History:

Please note any family health issues:

Brother(s) _____ Sister(s) _____
Father _____ Mother _____
Grandparents _____

#7 Chiropractic Goals:

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check (√) which statement best applies to your child:

___ My child has a specific problem and he or she requires help only with this problem.

___ After my child's specific problem has been relieved, I am interested in strategies to help ensure it does not return.

___ After my child's specific problem has been resolved and we have followed advice to help ensure it does not return, I am interested in strategies to improve my child's general health.

___ My child has no symptoms and feels well. I am interested in strategies to help my child feel and function even better.

I agree and understand that I am personally responsible for all charges relating to my care at the clinic. The clinic will provide me with the necessary paperwork upon request in order to make a claim with my health insurance plan. Furthermore, I give the doctor my consent to a complete health history, physical examination, and x-rays, if required, on my child.

Date: _____ Parent/Guardian's Signature: _____