

**Paediatric Chiropractic History Form**

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. 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. We look forward to working with you to build better health for your family.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Parents/ Guardians: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M/F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**Health History:** Many Childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine.

What is your purpose for contacting us? \_\_\_\_\_

Other Doctors seen for this condition and course of treatment: \_\_\_\_\_

Many childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine. Has your child suffered from any of the following in the past six months?

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Ear Infections    | <input type="checkbox"/> Dizzy/Clumsy       | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Recurring fevers      | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> Tonsillitis       | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> ADHD                  | <input type="checkbox"/> Temper Tantrums       | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Scoliosis             | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Colic             | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Chronic Colds         | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Other _____   |

Previous Chiropractor: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Paediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Number of doses of antibiotics your child has taken in past 6 months: \_\_\_\_\_ in lifetime: \_\_\_\_\_

Number of doses of prescription medications your child has taken in past 6 months \_\_\_\_\_ In lifetime: \_\_\_\_\_

List: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

Family History of Disease/Illness: \_\_\_\_\_

**Prenatal History:** Often, birth trauma can produce some of the first spinal problems in the delicate spine of a newborn.

Name of Midwife or Obstetrician: \_\_\_\_\_

Did you have any complications during your pregnancy: Y/N Explain: \_\_\_\_\_

Did you have ultrasounds during pregnancy: Y/N Number: \_\_\_\_\_

Did you smoke or consume alcohol during your pregnancy: Y/N

Were any of the following interventions used in your delivery (circle)?

Forceps Vacuum Extraction Induced Epidural C-section-planned or emergency Other: \_\_\_\_\_

Were there any complications during your delivery? Y/N Explain: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR at birth: \_\_\_\_\_ at 5minutes \_\_\_\_\_

**Feeding History:**

Was your child breastfed? Y/N For how long? \_\_\_\_\_

Was your child formula fed? Y/N For how long? \_\_\_\_\_ Type: \_\_\_\_\_

When did you first introduce solids? \_\_\_\_\_ months. When did you introduce cow's milk? \_\_\_\_\_ months.

Does your child have any food or juice allergies/intolerances? \_\_\_\_\_

**Developmental History:** Many childhood falls can produce long-term spinal misalignments that may surface many years later in life.

Has your child ever fallen from a change table, tree, bicycle, crib, stair or other height? Explain: \_\_\_\_\_

\_\_\_\_\_

Has your child ever been in a car accident? Y/N Explain: \_\_\_\_\_

Has your child ever had a sports injury or been involved in a high impact or contact sport (soccer, football, hockey, gymnastics, cheerleading, martial arts)? Y/N Explain: \_\_\_\_\_

Has your child ever had surgery or been seen on an emergency basis? \_\_\_\_\_

Menarche: Y/N Age: \_\_\_\_\_

We are here to serve you and encourage you to ask questions. Your participation in your family's care is vital and will help determine your child's results.

**Authorization for care of a minor:**

I, \_\_\_\_\_ (please print name of parent/guardian), hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_