Canton Dale Chiropractic

Child History Form

Date: _____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: _____ Date of Birth: _____

Address: _____

_____ Postal Code: _____

Doctor's Name: _____ Doctor's Address: _____

Name of Previous Doctor of Chiropractic: _____

Date of Last Visit (dd/mm/yyyy): _____

Child's Height: _____ Child's Weight: _____

Name(s) of Parent(s) or Guardian(s): _____

Business Telephone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____ _____

Witness: _____

What are your chief concerns, if any, with your child's health?

_____

_____

What is your main reason for contacting us?

_____

_____

List any other care your child has undergone with regards to this complaint including medication:

_____

_____

Date of onset (mm/yyyy): _____

Onset was: (circle one)
Sudden Gradual Associated with an event

Duration of problem or episode: (circle one)
Minutes Hours Days Months Years

Pattern of Problem: (circle one)
Constant Intermittent Occasional Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Other health concerns? _____

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History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? □ Yes □ No If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? □ No □Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? ____ Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

_____

The father's side? _____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No 3. Take supplements/vitamins? □ Yes □ No

4. Take drugs? □ Yes □ No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? □ Yes □ No If yes, how many?_____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long? _____ weeks months years

At what **age** was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? □Yes □ No If yes, which ones? _____ Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why? _____

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour problems? □ Yes □ No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify: _____

Did your child go to daycare? □ Yes □ No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth

□ Respiratory Depression □ Cord around neck □ Other _____

Any falls/accidents during pregnancy? □ Yes □ No Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? □ Yes □ No Please explain: _____

Does your child play sports? □ Yes □ No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx. Hours spent at play per week? _____ hrs