CHILD NEW PATIENT HEALTH HISTORY FORM

Many problems we see in adults have a start from the birth process itself or childhood trauma. Please complete these forms in full.

Patient Data

Infant/Child's Name:_____ **M / F** Address:_____
City:_____ Province: _____Postal Code: _____
Phone: H:_____ W:_____Ext:___ C: _____
Birth Date:_____ Age: _____ Family Physician: _____
Previous Chiropractor:_____ Reason for discontinuing? _____
Whom shall we thank for referring you to our office?_____
Do you have health insurance?_____ Name of company:_____ Plan number: _____
* Your Best Email Address:_____

Your email address will NOT be shared with anyone and will be used to email you your financial statements and for occasional office announcements. We are moving towards an entirely paperless office, so please help us by providing your email address. Thank you!

Mainly for Moms

What is the main reason for this check-up today? _____
Did you carry full-term? **Y N** Any complications: _____
Did you breastfeed? **Y N** How long?_____
Were you on any medications?_____
What is the pattern of this problem (circle)? *constant occasional comes and goes worsening*
When did it start? _____
If your child is experiencing pain, is it (circle): *dull sharp pins/needles burning tight throbbing*
What does it interfere with (circle): *sleep walking/standing sitting hobbies/leisure family*
When the problem is at its worst, how does it make your child feel?_____
What makes it better? _____ Worse? _____
Names of other doctors seen for this problem: _____
Please circle the intensity of your child's problem:

(healthy) **1 ------ 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10** (worst imaginable)

Please circle all that apply:

used a mid-wife	*hospital birth*	*had a C-section*
vacuum extraction	*forceps extraction*	*was induced*
had an epidural	*difficult birth*	*deemed healthy birth*

Infant/Child/Adolescent's Health History

As a baby/toddler (birth to 4 years), did any of the following occur (circle)?

Fall from a change table	*Frequent crying spells*
Tumble down stairs	*Frequent fevers*
Fall out of crib	*Frequent bouts of diarrhea*
Involved in car accident	*Constipation*
Fall off playground equipment	*Sleeping problems*
Play in "Jolly Jumper"	*Frequent colds*
Frequent ear infections	*Colic*
Tonsillitis	*Did not gain weight*
Reaction to vaccination	*Bed wetting*
Other: _____	

As a young child (5-12), did any of the following occur (circle)?

Fall from a tree
Fall of a bicycle
Fall of playground equipment
Sports accident
Car accident
Stomach pains
Scoliosis
Bed wetting
Hyperactivity/Autism
Learning difficulties
Asthma
Allergies
Leg/knee pains ("growing pains")
*Other*_____

Please check all that apply to your child's health:

- ❑ *Low Back Pain*
- ❑ *Pain Between Shoulders*
- ❑ *Neck Pain*
- ❑ *Headaches / Migraines*
- ❑ *Tired / Fatigued*
- ❑ *Tight Muscles*
- ❑ *Fibromyalgia*
- ❑ *Tension across shoulders*
- ❑ *Stress*
- ❑ *Forgetfulness*
- ❑ *Liver/gall bladder problems*
- ❑ *High blood pressure*
- ❑ *Numbing-Tingling in Hands/Feet*
- ❑ *Numbing-Tingling in Arms/Legs*
- ❑ *Dizziness*
- ❑ *Ringing in Ears*
- ❑ *Nervousness*
- ❑ *Attention Deficit Disorder*
- ❑ *Frequent colds*
- ❑ *Difficulty Sleeping*
- ❑ *Thyroid problems*
- ❑ *Depression*
- ❑ *Allergies / Sinus Problems*
- ❑ *Diarrhea / Constipation*
- ❑ *Asthma/allergies*
- ❑ *Weight Trouble*
- ❑ *Foot /Ankle Pain*
- ❑ *Mood swings*
- ❑ *Upset stomach*
- ❑ *Ankle swelling*
- ❑ *Bladder trouble*
- ❑ *Heartburn*
- ❑ *Chest pain*
- ❑ *Walking problems*
- ❑ *Confusion*
- ❑ *Balance problem*

Does your child (circle): *prolonged computer work* *sports* *prolonged postures* *sleep face down*

Medical History

Any hospital stays?_____
Approximately how many times have antibiotics been prescribed and for what condition?
_____
Any surgeries?_____
List all medications your child is currently taking: _____
My child's past health history has been (circle): *poor* *ok* *good* *very good* *excellent*
Has your child had any reactions to vaccinations?_____
Has your child been involved in an auto accident? **Y** **N** Date of accident: _____

To summarize, what is the primary purpose for this appointment? _____

Additional Information

Is there any other pertinent information you would like us to know? **Y** **N**
_____
_____

I give my consent to have the doctor perform an exam on my child and take any x-rays he deems appropriate to better understand my problem and monitor my progress.

Print Name: _____
Signature: _____ Date: _____
(Signature of parent/guardian required if patient under age 18)