

# 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  
vacuum extraction  
had an epidural*

*hospital birth  
forceps extraction  
difficult birth*

*had a C-section  
was induced  
deemed healthy birth*

## Infant/Child/Adolescent's Health History

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

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

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

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

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

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

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)