Office Use: Date: Patient #:

CHILD 5-18 **HEALTH HISTORY**

Welcome! *Please complete this form and bring it to your first appointment.*

PERSONAL/ PARENTAL INFORMATION

Name:		Age:
Address:	City:	Postal Code:
Home phone:	Cell phone:	Work phone:
E-mail address:	Birth date:	
Parents' names:		
How did you hear about our office? ☐ Website ☐ Internet ☐ Location ☐ Referral:		
Has your child ever been to a chiropractor before? ☐ Yes ☐ No		
Name of chiropractor:	City:	
Date of last visit:	Duration and frequency of care:	

BIRTH

Duration of gestation:	Duration of birth:			
Location of birth:				
Assisted? ☐ Yes ☐ No	**If yes:** ☐ forceps	☐ vacuum extraction	☐ C-section	☐ induced labour
Medications delivered to mother at birth?	☐ Yes ☐ No	If yes, what:		
Was the birth normal? ☐ Yes ☐ No				
Complications:				
APGAR? At birth:	After 5 min:			
Birth weight:	Birth length:			

GROWTH AND DEVELOPMENT

Did the child's development seem to follow a normal pattern?	☐ Yes ☐ No	
Explain:		
Do sleeping patterns seem normal to you?	☐ Yes ☐ No	
Explain:		
Family history of health problems (cancer, diabetes, heart disease, etc.):		
Mother's side:	Father's side:	Siblings:

CHEMICAL STRESSORS			
Was the child breast-fed? ☐ Yes ☐ No	How long?		
At what age was the child introduced to …	Formula:	Type:	
Cow's milk:	Solids:	Type:	
Commercial baby food:	Type:		
Food Intolerance? ☐ Yes ☐ No	Explain:		
During pregnancy, did the mother …	Smoke? ☐ Yes ☐ No	Drink alcohol? ☐ Yes ☐ No	
Take supplements? ☐ Yes ☐ No	Type:		
Have an illness? ☐ Yes ☐ No	Type:		
Take drugs? ☐ Yes ☐ No	Type:		
Have an ultrasound? ☐ Yes ☐ No	How many and medical reason:		
Have an invasive procedure? (Amniocentesis, CVS) ☐ Yes ☐ No	Type:		
Take antibiotics? ☐ Yes ☐ No	Type:		
Have a vaccination? ☐ Yes ☐ No	Type:	Reaction:	
Have pets at home? ☐ Yes ☐ No	Type:		
Have smokers at home? ☐ Yes ☐ No			
Has the child…			
Taken supplements? ☐ Yes ☐ No	Type:		
Had an illness? ☐ Yes ☐ No	Type:		
Taken antibiotics? ☐ Yes ☐ No	Type:		
Had a vaccination? ☐ Yes ☐ No	Type:		

PSYCHOSOCIAL STRESSORS			
Any difficulty with lactation? ☐ Yes ☐ No	**Any problems with bonding?** ☐ Yes ☐ No		
Any behavioral problems? ☐ Yes ☐ No	Type:	Onset:	
Night terrors, sleepwalking, sleep trouble?	☐ Yes ☐ No		
Explain:			
Average number of hours of screen time (TV, Cellphones, Computer) per week:			
Does your child seem normal for their age?	☐ Yes ☐ No		
Explain:			
Does your child experience high anxiety? ☐ Yes ☐ No			
Explain:			
Any difficulty with memory? ☐ Yes ☐ No	**Any problems with concentration?** ☐ Yes ☐ No		
Any difficulties with learning? ☐ Yes ☐ No			

PHYSICAL STRESSORS

Any evidence of birth trauma? Bruises, odd head shape, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, or other:

Any falls? (From furniture, in sports, in playground, etc.)

Any cuts, stitches, fractures, or bruises?

Any hospitalizations? ☐ Yes ☐ No Explain:

Any surgeries? ☐ Yes ☐ No Explain:

Sports played and age began: Hours per week:

Any hobbies that use repetitive movement? (Such as playing a musical instrument, playing video games, etc.)

The **nervous system** controls and coordinates all of your body functions. **Chiropractic care** is designed to correct misalignments that inhibit the nervous system, which in turn reduces body function. The following questions will help give us a complete picture of your child's health.

Check all conditions that your child has experienced (past or present):

☐ Cancer	☐ Difficulty Swallowing	☐ Stomach Pain	☐ Diabetes
☐ Unexplained Weight Loss	☐ Blurry/Double Vision	☐ Bloody Stools/Urine	☐ Allergies
☐ Chest Pain	☐ Chronic Cough	☐ Constipation/Diarrhea	☐ Ringing in ears
☐ Poor Circulation	☐ Difficulty Breathing	☐ Bowel Problems	☐ Depression
☐ High Blood Pressure	☐ Thyroid Dysfunction	☐ Incontinence	☐ Tremors
☐ Irregular Heartbeat	☐ Fever/Chills/Sweats	☐ Crohn's Disease	☐ Anxiety
☐ High Cholesterol	☐ Fainting/Convulsions	☐ Arthritis	**Women Only**
☐ Slurred Speech	☐ Spitting Blood	☐ Painful Urination	☐ Painful cycles
☐ Frequent Colds/Flus	☐ Nausea or Vomiting	☐ Waking to Urinate	☐ Irregular cycles

Check all other conditions that your child has experienced:

☐ Irritable/Nervousness	☐ Sleeping Difficulty	☐ Low Energy	☐ ADHD
☐ Skin Problems	☐ Poor Digestion	☐ Poor Memory	☐ Sensory Deprivation
☐ Dizziness	☐ Headaches	☐ Poor Concentration	☐ Autism

What would you like to gain from chiropractic care?

Any other concerns we should know about?

How can we make your experience in our office even better?

I, _____, give consent to receiving email reminders for my child's chiropractic appointments.

Signature: _____ Date: _____