Office Use: Date: Patient #:

arc of life CHIROPRACTIC

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:	
Gender: ☐ Female ☐ Male ☐ Other:		
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 appointments.
Print Name

_____ _____
Signature Date