Chiropractic – Child

File #: ______________________

Date: ______________________

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
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E info@wvchirogroup.ca

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General Information - Child

How do you wish to be contacted by our office regarding your child's care?

☐ Email ☐ Phone

CHILD'S INFORMATION

Last Name: ______________________ **First Name:** ______________________

D.O.B. (d/m/yr) ________/________/________ **Sex:** M F

Present Length/Height: ______________________ **Weight:** ______________________

Parent(s)' Names:

Last: ______________________ **First:** ______________________

Last: ______________________ **First:** ______________________

Parental Status: ☐ Married ☐ Divorced **Custodial Status:** ☐ Joint ☐ Single Parent

Siblings (include ages): ______________________

Address: ______________________

Town/City: ______________________ **Postal Code:** ______________________

Home Phone: ( ) ______________________ **Parent(s) Cell Phone: ( )** ______________________

Email: ______________________ __________ **Please Initial** I consent to receive email communication from the clinic

Referred by: ______________________

How did you decide to choose our office? ______________________

Family Dr. Name: ______________________ **Phone: ( )** ______________________

Date of last Medical Doctors visit and reason: ______________________

Previous Wellness Care? (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

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A. HEALTH CONCERNS:

Reason for consulting the office: ☐ **Spinal Check** ☐ **Other Complaint**

Explain:____

List other care undergone for this complaint (Including medications): ____________________________

____

Date of onset: _/______/______ **Onset was: Sudden / Gradual / Associated with an event**

Duration of problem (episode): _____________ **minutes / hours / days / months / years**

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Initiating factors: ____

Aggravating factors: ____

Relieving factors: ____

Effects of problems on body function and daily activities: _______________________________________

____

Other Health Concerns: ____

____

B. HISTORY OF BIRTH: *(Please circle all that apply)*

Hospital **Home** **Medical** **Midwife**

Duration of Gestation: _______ **weeks**

Assisted birth? YES NO **If yes: forceps / vacuum extraction / c-section / induced labour**

Medications delivered to mother at birth? YES NO **If yes, what?**_________________________________

Duration of birth: ____

Complications at birth? YES NO Explain: ____

Was delivery normal? YES NO Explain: ____

APGAR at Birth (if known): _________________ **After 5 Minutes:** ______________________________

Birth Weight: _______________ **Birth Length:** ___________________________________

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C. GROWTH AND DEVELOPMENT:

Was the infant alert and responsive within twelve hours of delivery? YES NO

Has your child met their developmental milestones at the appropriate times? YES NO

(If no, explain): ____

Does their sleeping pattern seem normal to you? YES NO Explain: ____________________

____

Any health issues (cancer, diabetes, heart disease, etc.) on the mother's side of the family?

____

On the father's side? ____

With siblings? ____

D. CHEMICAL STRESSORS: *Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:*

Was the baby breast-fed? YES NO **How long?** ____________________

Food intolerance? YES NO **Type:** ____________________

Any illness of the mother during pregnancy? ____

Any health supplements taken by the mother during pregnancy? ____________________

____

Any drugs taken during pregnancy? ____

Any exposures to ultrasound? YES NO **If so, how many and what was the medical reason:**

____

Any invasive procedures? (amniocentesis, CVS, etc.): ____________________

Any smokers in the home? YES NO **How much:** ________________

Any vaccinations? YES NO **Which ones and were there any reactions:** ____________________

____

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Any antibiotics? YES NO

For what conditions: ____

Total number of courses of antibiotics to date: ______________________________

E. PSYCHOLOGICAL STRESSORS:

Any difficulties with lactation? YES NO

Any behavioural problems? YES NO Onset: ______________________________

Any night terrors, sleep walking, difficulty sleeping? YES NO Specify: ______________

____

Does your child seem normal for their age? YES NO Explain: ______________

____

F. TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents)? YES NO

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

____

Any falls from couches, beds, change tables? YES NO

Any traumas with bruising, cuts, stitches, fractures? YES NO

Any hospitalizations? YES NO Explain: ______________________________

____

Any surgeries or organs removed? YES NO Explain: ______________________________

____