File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

General Information: Child

Child's Last Name: _____ **Child's First Name:** _____

D.O.B.: _____

Present Length/Height: _____ **Weight:** _____

Identify as? ☐ **M** ☐ **F** ☐ **Other:** _____ **Sex at Birth:** ☐ M ☐ F

Parent Last: _____ **First:** _____

Parent Last: _____ **First:** _____

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

Siblings: *(Include Ages:)* _____

Address: _____

Town/City: _____ **Postal Code:** _____

Home Phone: _____ **Primary Cell Phone:** _____

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

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

How did you hear about us? *(referral, ad, Google)* _____

Family Dr. Name: _____ **Phone:** _____

Previous Wellness Care? (check all that apply)

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: _____

Reason for consulting the office:

- ☐ My child has a specific problem and requires help only with this problem.
- ☐ After my child's specific problem has been relieved, we are interested in strategies for maintenance.
- ☐ After my child's specific problem has been resolved, and we understand methods to ensure it does not return, we are interested in strategies to improve my child's general health.
- ☐ My child has no symptoms and feels well. We are interested in strategies to help my child continue to feel well, or even better.

Chiropractic – Child

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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 check 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:** _____

File #: _____

C. GROWTH AND DEVELOPMENT:

Was the child 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 child breast-fed? ☐ YES ☐ NO **How long?** _____

Food intolerance(s)? ☐ 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 / vapers in the home? ☐ YES ☐ NO **Frequency:** _____

Any vaccinations? ☐ YES ☐ NO **Which ones and were there any reactions?** _____

_____

File #:_____

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: _____

_____