HealthFirst CHIROPRACTIC & Wellness Centre

Pediatric Forms (0-7 Years)

Today's Date: _____

Information reviewed with parent/guardian:

Dr. Initials _____

Name of child: _____ Sex: M / F

Date of Birth: _____ Age: _____

Parent's Names: Mother _____

Father _____

Address: _____

City: _____ Postal Code: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell: (___) _____

Preferred number (circle one): Home / Work / Cell

Email: _____ ☐ I do not want to be contacted via email

Medical Doctor/Pediatrician: _____ Date of last visit: _____

MSP #: _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

Has your child ever received Chiropractic care? Yes / No

If yes, who? _____ Approximately when? _____

How did you hear about our office? _____

Who may we thank for referring you? _____

What concerns do you have regarding the health of your child? When did it start? How did it start?

_____

_____

_____

LIFE EVENTS

PREGNANCY

How many weeks did you carry? _____

Did you require any medication or surgeries during this pregnancy? Yes / No

Did you have any complications through your pregnancy? Yes / No

_____

_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions about the delivery and birth of your child.

Home / Hospital Delivery		Midwife / Obstetrician	
Delivered Normally	Yes / No	Breech	Yes / No
Premature	Yes / No	Caesarian	Yes / No
At Term	Yes / No	Forceps	Yes / No
Late	Yes / No	Suction	Yes / No
Chemically Induced	Yes / No		

Other: _____

_____

Birth Weight: _____

How long were you in labour? _____ Hours

Do you believe the birth was traumatic for your child? Yes / No

Was your child's head misshapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details: _____

_____

_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _____

Was your child formula fed? Yes / No What type of formula? _____

Did your child suffer from colic? Yes / No If yes, how bad was it? Mild Moderate Severe

Did your child suffer from reflux? Yes / No If yes, how bad was it? Mild Moderate Severe

Would you say your child was a:

Very poor sleeper / Poor sleeper / Average sleeper / Good sleeper / Very good sleeper

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies	Neck Pain
Back Pain	Constipation/Diarrhea	Earaches/Infections
Sinus Pain	Recurrent Tonsillitis	Bedwetting
Recurrent Chest Infections	Growing Pains	Hyperactivity
Loss of Appetite	Poor Sleeping Habits	Visual Disorders
Constant Fatigue	Arm/Leg Pains	Recurrent Stomach Aches
Scoliosis	Fever	Convulsions
Joint Pains	Asthma	Travel Sickness
Night Terrors	Seizures	Chronic Colds
Recurrent Fevers	Hip Problems	Digestive Disorders
Developmental Delay	Poor Social Skills	Messy Eater

Other: _____

_____

SCHOOL AGE CHILD:

Poor Co-ordination	Learning Difficulties	Poor Handwriting
Behavioural Issues	Diagnosed as ADD/ADHD	Delayed Verbally
Diagnosis of Autism	Difficulty Reading/Writing/Spelling	
Communication	Extreme Clumsiness	

Other: _____

_____

MEDICAL HISTORY

What age did your child begin crawling? _____

Is your child accident prone? Yes / No Any significant falls? Yes / No

Please describe any falls or accidents your child has had: _____

_____

_____

Has your child ever been involved in a motor vehicle accident? Yes / No

Has your child had any diseases/illnesses? Yes / No Details: _____

Has your child ever been hospitalized or had surgery? Yes / No Details: _____

_____

Has your child ever had any broken bones or sprain injuries? Yes / No Details: _____

_____

Is your child on medication? Yes / No If yes, explain: _____

How many doses of antibiotics has your child been on in the last six months? _____