

CHILD PATIENT HEALTH RECORD

ABOUT THE CHILD

Patient Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____

Date of Birth: _____ Age: _____

Gender: _____ Weight: _____

ABOUT THE PARENT

Parent/Legal Guardian Name: _____

I am the child's parent _____ I am the child's legal guardian _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___

Address: Same as above ___ or list below

Home Phone: _____ Cell Phone: _____

Email Address: _____

CHIROPRACTIC EXPERIENCE

Who referred you to our office? _____

Newspaper ___ Sign ___ Yellow Pages ___ Event ___ Mailing ___

Has any member of your family ever seen a chiropractor?

Yes ___ No ___

REASON FOR THIS VISIT

Describe the reason for this visit:

Wellness Check _____ Condition/Problem _____

If condition, please describe _____

Is the purpose of this appointment related to:

Sports ___ Auto ___ Fall ___ Home Injury ___ Other ___

Please explain: _____

When did this condition begin? _____

Has this condition:

Got Worse ___ Stayed Constant ___ Come & Gone ___

Does this condition interfere with:

Sleep ___ Daily Routine ___ Other Activities ___

If so please explain: _____

Has this condition occurred before? Yes ___ No ___

If so please explain: _____

Have you seen other doctors or chiropractor for this condition?

Yes ___ No ___

Doctor's Name: _____

Type of Treatment _____

Results: _____

PRENATAL HISTORY

Location of Birth: Home ___ Birthing Center ___ Hospital ___

Describe your delivery:

Labor Chemically Induced ___ Labor was Doctor Assisted ___ C-Section Delivery ___ Forceps/Vacuum Extraction ___

C-Section Delivery ___ Forceps/Vacuum Extraction ___ Doctor Pulled or Twisted Baby ___ Premature Delivery ___

Please explain: _____

Describe any complications experienced during delivery:

Did you experience any illness while pregnant? Yes ___ No ___ Please explain: _____

Please describe any genetic or disabilities: _____

Birth Weight: ___ Birth Length: ___ Apgar Score: ___ Ultrasound During Pregnancy? Yes ___ No ___ How Many ___

Did you breastfeed? Yes ___ No ___ If yes, how long? ___ Did you formula feed? Yes ___ No ___ If yes, how long? ___

At what age did you introduce: Solids ___ Cows Milk ___ Are you aware of any food or juice allergies or intolerance?

Are you aware of any food or juice allergies or intolerance? Yes ___ No ___ Please list: _____

LIFESTYLE BEHAVIORS

Does your child exercise daily? Yes ___ No ___ How much? _____

Does your child drink soda? Yes ___ No ___ How much? _____

Does your child take vitamins? Yes ___ No ___

Does your child watch more than 1 hour of TV per day? Yes ___ No ___ How much? _____

Does your child eat balanced meals? Yes ___ No ___

Does your child experience prolonged sadness? Yes ___ No ___ Please explain: _____

COMPLETE THIS SECTION FOR CHILDREN INFANT TO 5 YEARS OF AGE

CHILD'S HEALTH HISTORY

Please check off each of the diseases or conditions that apply now or in the past. While they may seem unrelated to the purpose of this Appointment, they can affect the overall diagnosis, care plan and possibility of being accepted for care.

Acid Reflux	Constipation	Frequent Colds/Coughs	Hyperactivity
Asthma	Diarrhea	Bed Wetting	Difficult Weight Gain
Ear Infections	Colic	Learning Disorders	Sleeping Difficulties

CURRENT HEALTH STATUS

The national safety council reports approx. 50% of children fall head first from a high place during their first year of life (ie.bed etc.)

Was this the case for your child? Yes ___ No ___ Please explain: _____

Has your child ever been hospitalized or had surgery? Yes ___ No ___ Please explain: _____

Has your child ever been in a car accident? Yes ___ No ___ Please explain: _____

Does your child have trouble interacting with others? Yes ___ No ___ Please explain: _____

Have you or anyone else noticed your child is nervous, twitches, shakes or exhibits rocking behaviour? Yes ___ No ___

COMPLETE THIS SECTION FOR CHILDREN 5-10 YEARS OF AGE

CHILD'S HEALTH HISTORY

Please check off each of the diseases or conditions that apply now or in the past. While they may seem unrelated to the purpose of this Appointment, they can affect the overall diagnosis, care plan and possibility of being accepted for care.

Asthma	Ear Infections	Sore Throat	Bed Wetting
Headaches	Upset Stomach	Bronchitis	Hyperactivity
Urinary Infections	Constipation	Learning Disorders	Diarrhea
Sleeping Difficulties			

CURRENT HEALTH STATUS

Has your child been involved in any high impact/contact type sports (ie.soccer, football, martial arts, cheerleading)

Yes ___ No ___ Please list: _____

Has your child ever been hospitalized or had surgery? Yes ___ No ___ Please explain: _____

Has your child ever been in a car accident? Yes ___ No ___ Please explain: _____

Does your child have difficulty interacting with others? Yes ___ No ___ Please explain: _____

Have you or anyone else noticed your child is nervous, twitches, shakes or exhibits rocking behaviour? Yes ___ No ___

COMPLETE THIS SECTION FOR CHILDREN 11-18 YEARS OF AGE

CHILD'S HEALTH HISTORY

Please check off each of the diseases or conditions that apply now or in the past. While they may seem unrelated to the purpose of this Appointment, they can affect the overall diagnosis, care plan and possibility of being accepted for care.

Anxiety	Depression	Learning Disorders	Asthma
Neck Pain/Stiffness	Painful/Irregular Periods	Back Pain/Stiffness	Headaches
Shoulder/Elbow/Wrist	Constipation	Hips/Knees/Ankles	Stress
Diarrhea	Hyperactivity	Urinary Infections	

CURRENT HEALTH STATUS

Has your child been involved in any high impact/contact type sports (ie.soccer, football, martial arts, cheerleading)
Yes ___ No ___ Please list: _____

Has your child ever been hospitalized or had surgery? Yes ___ No ___ Please explain: _____

Has your child ever been in a car accident? Yes ___ No ___ Please explain: _____

Does your child have difficulty interacting with others? Yes ___ No ___ Please explain: _____

Please rate stress levels on a scale of 1-10 (10 being high)

School: 1 2 3 4 5 6 7 8 9 10

Personal: 1 2 3 4 5 6 7 8 9 10