Centre Chiropratique Spécifique – **Dre Isabelle Ayers**

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CHILD HISTORY FORM

PRESENT DATE: _____

PLEASE COMPLETE THIS DETAILED HISTORY FORM AND RETURN IT TO THE RECEPTIONIST.
SHOULD YOU REQUIRE ANY ASSISTANCE, PLEASE LET US KNOW, AS WE WOULD BE HAPPY TO ASSIST.

NAME_____ TELEPHONE #_____

ADDRESS_____ POSTAL CODE_____

DATE OF BIRTH_____ REFERRED BY_____

Present MD & Address:_____

Date of last MD visit & reason:_____

Previous DC name and last visit:_____

Present Length_____ Weight_____

AUTHORIZATION FOR CARE OF A MINOR

PARENTS NAMES_____ Work telephone:_____

I hereby authorize and consent to the chiropractic evaluation (including X-Rays if necessary) and care of my child.

Parent / Guardian signature_____ Witness_____

CHIEF HEALTH CONCERNS:

REASON FOR CONTACTING US:_____

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:_____

_____

Prior occurrence or episodes:_____

OTHER HEALTH CONCERNS:_____

_____

_____

_____

_____

_____

_____

_____

See other side

HISTORY OF BIRTH:

- Hospital birthing center home medical midwife
- Duration of Gestation_____ weeks
- Assisted birth: No Yes. If yes: forceps, vacuum extraction, c-section, induced labour
- Medications delivered to mother at birth? No Yes, If yes what? _____
- Duration of birth: _____
- Complications at birth: No Yes Explain _____
- Was delivery normal? Yes No _____
- APGAR at BIRTH_____ AFTER 5 MINUTES_____
- BIRTH WEIGHT _____ BIRTH LENGTH _____

GROWTH & DEVELOPMENT

- Was the infant alert and responsive within twelve hours of delivery? Yes No
  (Explain)_____
- At what age did the child: Respond to sound_____ Follow an object_____
  Hold up head_____ Vocalize_____ Sit alone_____
  Teethe_____ Crawl_____ Walk_____
- Does sleeping pattern seem normal to you: Yes No Explain_____
- Any health problems (cancer, diabetes, heart disease, etc.) on the mother's side of the family_____
  On the father's_____ With siblings_____

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

CHEMICAL STRESSORS

- Was this baby breast-fed? No Yes How long_____
- Formula introduced at age_____ Type of formula used _____ Introduction of cow's milk at age _____
- Began solid foods at age_____ Type_____ Age & type of commercial baby food introduction_____
  Food / Juice intolerance No Yes Types: _____
- During pregnancy did the mother smoke? Yes No
  Did the mother drink alcohol? Yes No
  Any illness of the mother during pregnancy: _____
  Any supplements of mother during pregnancy: _____
  Any drugs taken during pregnancy: _____
  Any exposures to ultrasound: No Yes. If so, how many and what was the medical reason? _____
  Any invasive procedures (amniocenteses, CVS): _____
- Any pets at home: No Yes _____
  Any smokers in the home: No Yes (How much) _____
- Any vaccinations: Which ones and any reactions: _____
  Any antibiotics: No Yes Explain:_____
- Total number of courses of antibiotics to date: _____

PSYCHOSOCIAL STRESSORS

- Any difficulties with lactation: No Yes _____
- Any problems with bonding: No Yes _____
  Any behavioural problems: No Yes Onset: _____
  Any night terrors, sleep walking, difficulty sleeping: No Yes Specify_____
- Age of child when began daycare: _____
- Average number of hours of television / week _____
- Does your child seem normal for their age? Yes No Explain_____

TRAUMATIC STRESSORS

- Any traumas during pregnancy (falls, accidents) _____
- 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 _____
- Any traumas with bruising, cuts, stitches, fractures _____

_____

- Any hospitalizations: No Yes Explain _____
- Any surgeries or organs removed _____
- Sports played and age began _____
- Number of hours per week played _____
- Weight of school backpack _____
- Approx. hours spent at play per week _____

Thank you for completing this form. Please write any other questions you have below.

_____

_____

_____