715 Hewitson St.
Suite 1004 Towncentre Building
Thunder Bay, ON P7B 5M6
807-628-0718

Child and Pediatric Health History Form

Name: _____ Date of Birth: _____ Age: _____ Sex: M ___ F ___

Address: _____ City: _____ Province: _____ Postal Code: _____

Parent's Home Phone: _____ Parent's Work Phone: _____

Parent's and Sibling's Names: _____

Parent's Email Address: _____

Who may we thank for referring you? _____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern

Health Concern: _____

When did it begin? _____

What relieves it? _____ How often does it occur? _____

What aggravates it? _____

Other Professionals Seen For Concern: _____

Treatment and Results: _____

Birth History

Child's gestational age at birth _____ weeks Birth Weight _____ Length _____

Birth experience: _____ Midwife _____ Medical Labour: _____ Spontaneous _____ Induced

Any procedures during birth? _____ Forceps _____ Vacuum Extraction _____ C-section ____ Episiotomy

Any complications before or after birth? ( ) Yes ( ) No

If yes, please explain: _____

Evidence of obvious birth trauma? _____ Bruising _____ Odd shaped head _____ Stuck in birth canal _____ Cord around neck

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Family Health History

Please not any health issues that are present with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Physical Stresses

During pregnancy, did the mother: use medication? ( ) Yes ( ) No If yes, which ones? _____

Smoke? ( ) Yes ( ) No Drink? ( ) Yes ( ) No

Was the child breast-fed? ( ) Yes ( ) No If yes, how long? _____

Formula introduced at what age? _____

Began solid foods at what age? _____

Vaccination history: Vaccinations given: _____

Any reactions? ( ) Yes ( ) No If yes, please list: _____

Has the child been or is the child currently on any medications? ( ) Yes ( ) No

If yes, please list: _____

Mental / Emotional Stresses

Any problems with bonding? ( ) Yes ( ) No ( ) Unsure

Any behavioural problems? ( ) Yes ( ) No ( ) Unsure

Any night terrors, sleeping walking, difficulty sleeping? ( ) Yes ( ) No ( ) Unsure

Average number of television hours per week? _____

Do you feel that your child's social and emotional development is appropriate for their age?

( ) Yes ( ) No ( ) Unsure

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Authorization For Care of a Minor (Under 16 Years Of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic staff.

Child's Name: _____ Parent's Name: _____ Date: _____

Parent's Signature: _____ Witness: _____

Thank you for completing this form. If you have any further concerns, please note them in the space below:

_____

_____

_____

_____