Date: _____

Patient No.: _____

PEDIATRIC HEALTH HISTORY

Child's Name: _____ Sex: Female ☐ Male ☐
Parents: _____ _____ Number of Children: _____
Address: _____City/Province: _____ Postal Code_____
H. Phone: _____ Date of Birth: _____/_____/_____ Age: _____
Medical Doctor: _____ Last Visit to MD: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Whom may we thank for referring you? _____
Alberta Health Care #_____ Has your child ever received chiropractic care? No ☐ Yes ☐ If yes: Dr. _____ Approx. Date of Last Visit: _____

EVENTS

There are many events that occur throughout childhood- starting with childbirth, then learning how to walk, and playing childhood sports. These events can cause accumulated stress and result in loss of health potential. Most times the effects are gradual, not even felt until we become adults. Answering the following questions will give us an understanding of your child's overall health and allow us to better assess their body's innate ability to be healthy. Please check ✓ the following.

Tell us about your pregnancy:

Did you carry to full term (40 weeks)? _____ If not, how many weeks gestation? _____
Did you consume alcohol during your pregnancy? ____ Did you smoke? ____
Did you take any medication during your pregnancy? Details:_____
Describe any complications and when they occurred: _____
_____

Tell us about your labour and delivery of this child:

Did you use a midwife? ____ Obstetrician? ____ Home birth? ____ Hospital? ____
Did you have a C-Section? ____ Vaginal birth? ____
Were you induced? ____ Epidural? ____ Were forceps used? ____ Vacuum Extraction? ____
Was there initial respiratory delay? ___ Purple markings on face? ___ Mis-shaped skull? ___
Jaundice? ___ Describe any problems during labour and delivery? _____
_____

Tell us about your child:

Did you breastfeed? _____ How long? _____ Bottle feed? ____ Formula? ____
Number of hours your child sleeps per night? ____ hrs. Quality of sleep: good ____ poor __
Was your child vaccinated? _____ List any vaccine reactions: _____
Were you told that you had a choice in vaccinating your child? YES ____ NO ____
List any <u>current</u> medications or supplements your child is taking: _____
List any <u>previous</u> medication(s), for what condition, and the number of times it was prescribed: _
_____
List any emergency/hospital visits:
_____ _____

As a baby/toddler (birth-4 years), did any of the following occur?

___ Fall from change table/crib ___ Bed wetting
___ Tumble down stairs ___ Frequent fevers
___ Involved in a car accident ___ Frequent bouts of diarrhea
___ Play in "Jolly Jumper" ___ Did not gain weight
___ Fall off playground equipment ___ Sleeping problems
___ Constipation ___ Frequent colds
___ Frequent ear infections ___ Colic

___ Reaction to vaccination ___ Other_____

As a young child (5-12 years), did any of the following occur?

___ Fall from tree/playground equipment ___ Bed wetting
___ Fall off a bicycle ___ Hyperactivity/Autism
___ Sports accident ___ Asthma
___ Car accident ___ Allergies
___ Stomach pains ___ Leg/knee pains
___ Scoliosis ___ Frequent colds
___ Learning difficulties ___ Other_____

SYMPTOMS AND ILL HEALTH

As a child or adolescent, has your child experienced any of the following?

___ Headaches ___ Arm/wrist pains ___ Foot/ankle/knee pains
___ Dizziness ___ Neck/back pains ___ Tingling in arms/legs
___ Ringing in ears ___ Sleeping problems ___ Shoulder pains
___ Asthma ___ Allergies ___ Fatigue ___ Hyperactivity
___ Stomach problems ___ "Growing Pains" ___ Weight gain/loss
___ Other: _____

Present reason for consulting our office:

- ☐ Maximizing personal and / or family health potential?
- ☐ Correction and prevention of an existing problem?

Please fill out the information below.

If your child has symptoms or a complaint, briefly describe the problem here.

_____
_____

How and when did this problem start?

_____

The problem is: Constant ____ Comes & Goes ____ Radiates/Travels *(where?)*

_____

If he/she is experiencing pain, is it: Sharp ___ Dull ___ Throbbing ___ Aching ___ Shooting ___ Nagging ___

What aggravates the condition / pain?_____

What relieves the condition / pain?_____

Please describe any past or current treatment(s) and results:

_____

Is there anything else you would like us to know?

_____
_____
_____
_____
_____
_____

Dr. Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____