

Child Health History Form

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Personal Information

Child's Name: _____ Date: _____

Child's Age: _____ Birth date: _____ Sex: M F

Parent (s) Name: Mother _____ Father _____

Sibling's Names & Ages: _____, _____, _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Other Number: _____

E-mail _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care? Yes No

If yes, who is your child's previous Doctor of Chiropractic?: _____

The date of last visit: _____

The reason for the last visit: _____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent tests done (list date beside): Bloodwork _____ Urine _____ XRays _____

Please indicate the purpose for your child's visit:

Crisis management Early detection of problems Prevention Wellness

Maximizing normal growth and development Other: _____

Authorization for Care of a Minor (under 18 years)

Parent(s) Name: _____ Work Telephone: _____

I hereby authorize and consent Dr. Seán Manning to administer care as deemed necessary to my child.

Parent/Guardian Signature: _____

Date: _____ **Witness:** _____

Present Health Concerns

Major _____

Minor _____

When did this problem begin? _____

Is this problem: occasional frequent constant intermittent

Does problem radiate? Yes No If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No

If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

Often seemingly unrelated symptoms can manifest as other health concerns. Please indicate if your child has had any of the following:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chest pressure | <input type="checkbox"/> weight loss | <input type="checkbox"/> dizziness | <input type="checkbox"/> breast pain |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> irritability | <input type="checkbox"/> frequent colds | <input type="checkbox"/> dental problems | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> fevers | <input type="checkbox"/> depression | <input type="checkbox"/> sore throats | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> sinus congestion |
| <input type="checkbox"/> asthma | <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats | <input type="checkbox"/> bronchitis | <input type="checkbox"/> loss of concentration |
| <input type="checkbox"/> weakness | <input type="checkbox"/> heartburn | <input type="checkbox"/> pneumonia | <input type="checkbox"/> muscle cramps | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> poor coordination | <input type="checkbox"/> ears buzzing | <input type="checkbox"/> vision changes | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> upper back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> loss of smell |
| <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain | <input type="checkbox"/> constipation | <input type="checkbox"/> radiating pain | <input type="checkbox"/> light sensitivity |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> face flushed | <input type="checkbox"/> urinary problems | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> stiffness | <input type="checkbox"/> reduced mobility | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> numbness in feet | <input type="checkbox"/> ear pain/infections |

loss of balance

Other: _____

Birth History

What was the child's gestational age at birth? _____ weeks.

Birth weight _____ lbs _____ oz Birth length _____ inches

Was your child's birth: at home in a birthing center hospital

Birth History (continued)

Was the birth considered: medical midwife Duration of birth: _____ hours

Was child born: cephalic (head first) breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labor: spontaneous induced

Were medications or epidurals given to the mother during birth? Yes No

APGAR score: at Birth ____/10 After 5 minutes ____/10

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold up head _____

Vocalize _____ Sit alone _____ Teethe _____ Crawl _____ Walk _____

Does your child sleep: front back side

Do you consider the child's sleeping pattern normal? Yes No How many hours per day? _____

If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) __ Yes __ No

If yes, please explain _____

Any evidence of birth trauma to the infant?

bruising odd shaped head stuck in birth canal cord around neck

fast or excessively long birth respiratory depression

Physical Stressors (continued)

Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No

If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No Is it heavy or light?

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child on or have taken any medications? _____

During the mother's pregnancy:

Did the mother smoke? Yes No How much? _____

Drink alcohol? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, describe: _____

Any supplements taken during pregnancy? Yes No If yes, describe: _____

Any drugs taken during pregnancy? Yes No _____

Any ultrasounds? Yes No How many: _____ Reasons for being done: _____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? Yes No

If yes, please explain _____

Any pets at home? Yes No _____

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

Psychosocial Stressors

Any difficulties with lactation? Yes No _____

Any problems with bonding? Yes No _____

Psychosocial Stressors (continued)

Any behavioral problems? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Age of child when began daycare? _____ Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

Doctor's Notes:
