CHILDREN'S HEALTH HISTORY FORM

PERSONAL HISTORY OF CHILD

Child's Name: ____________________ Date of Birth: ____/____/______ (MM/DD/YY)

Parent/Legal Guardian Names: ____________________

Address: ____________________ City: ____________________

Province: __________ Postal Code: __________ Age of Child: ________ Gender: ☐ M ☐ F

Telephone #: Hm. (_____)______-________ Cell (_____)_____-________ Bus. (______)_______-_________

E-mail Address: ____________________

Name of Medical Doctor: ____________________ Tel.: (________) ________-______________

Date of most recent Doctor's visit: ______/______/________ (MM/DD/YY)

Health Card #____________________ Version Code ________ Expiry Date ____________________

How were you referred to this clinic? ☐ Phone Book ☐ Friend ______________ ☐ Other______________
☐ Sign ☐ Parent ______________

Has your child seen a Chiropractor before? ☐ Yes ☐ No

If YES: Name ____________________ X-Rays Taken: ☐ Yes ☐ No

Date of Last Treatment: _______/_______/________ (MM/DD/YY) Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

>>>>>> *AUHORIZATION FOR CARE OF A MINOR* <<<<<<

I ______________________________ hereby authorize and consent to the chiropractic evaluation and care of my child and whoever may be designated as an assistant to administer chiropractic care as deemed necessary.

Parent/Guardian Signature: ____________________ Witness: ____________________

CURRENT HEALTH HISTORY OF CHILD

Reason(s) for consulting this office / Current Complaints: ____________________

Goals of seeking therapy: ____________________

List other care undergone for this complaint including medications: ____________________

____

PAST HEALTH HISTORY OF CHILD

Has your child ever had, or does your child currently suffer from, any of the following:

☐ Headaches	☐ Allergies	☐ Ear Problems	☐ Sleeping Difficulty	☐ Fatigue
☐ Irritability	☐ Hyperactivity	☐ Bloody Noses	☐ Breathing Problems	☐ Heart Disease
☐ Frequent Colds	☐ Meningitis	☐ Diarrhea	☐ Constipation	☐ Colic
☐ Digestive Problems	☐ Bed Wetting	☐ Rashes	☐ Susceptible to the Flu	☐ Poor Posture

☐Other: ____________________

FAMILY HEALTH HISTORY

Have you or anyone in your family had any of the following (please specify whom):

☐ Heart Disease: ____________	☐ High Blood Pressure: ____________
☐ Cancer: ____________	☐ Stroke: ____________
☐ Diabetes: ____________	☐ Arthritis: ____________
☐ Back Pain: ____________	☐ Headaches: ____________
☐ Mood Disorders: ____________	☐ Other: ____________

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DETAILS OF PREGNANCY AND LABOUR OF YOUR CHILD

Duration of Pregnancy: ________ weeks

During pregnancy: **Was the mother on any medication: ☐ Yes ☐ No**

If YES. please list: ____

Did the mother smoke: ☐ Yes ☐ No

Did the mother consume any alcoholic beverage: ☐ Yes ☐ No

Was the mother physically ill (ie. colds, flu, chicken pox, etc.): ☐ Yes ☐ No

If YES please provide details: ____

Was Labour: ☐ Normal ☐ Chemically Induced ☐ Doctor Assisted

Was a C-Section performed: ☐ Yes ☐ No, Were forceps used: ☐ Yes ☐ No, Vacuum Extraction: ☐ Yes ☐ No

At Birth: Weight_________________ Length__________________

LIFESTYLE AND HABITS OF YOUR CHILD

Any issues with developmental milestones? ☐ YES ☐ NO If YES, explain: _________________________________

____

How many hours does your child sleep per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12 +

Does your child sleep through the night: ☐ YES ☐ NO

Was your child breast fed: ☐ Yes ☐ No If yes, for how long?____________________

Formula Introduced: ________________________________ Type: ___________________

How many meals does your child have a day: ☐ One ☐ Two ☐ Three ☐ Four ☐ More than four

Rate your child's appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your child's diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Date of your child's last dental examination: _______/_______/___________ (MM/DD/YY)

Please list any medications/supplements your child has taken or is currently taking: ___________________________

____

Please list any significant trauma, falls and/or accidents your child has had: ___________________________________

____

Please list and date any previous surgeries or hospitalization your child has had: ______________________________

____

FINANCIAL INFORMATION

Payment in full is expected as treatment is rendered. If you are interested in pre-paid packages please speak with one of our staff. Our office accepts Cash, Cheque, Interac, VISA and Mastercard.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. We will direct bill whenever possible. You are responsible to settle your account with our office. We will gladly supply you detailed receipts for you to submit to your insurance company for reimbursement.

Legal Guardian Signature: _________________________________ Date: _______/_______/___________ (MM/DD/YY)

PRIVACY POLICY

Our Privacy Policy is in accordance with the Personal Information Protection and Electronic Documents Act. A detailed copy of our privacy policy can be made available upon request.

AFTER YOUR VISIT

Treatment Follow-Up:

Permission to leave message ☐ YES ☐ NO

Appointment Reminder Calls/Cards:

Permission to leave message/mail/email ☐ YES ☐ NO