Chiropractic Child Health History Questionnaire

santē | chiropractic wellness

Child's Name

Parent(s) Name

Parent's email

Date

Month Day Year

Address

Cell/Home Phone

Date of Birth of child

Referred by:

Has your child ever received chiropractic care?

Yes ☐ No ☐

If yes, previous DC's name and last visit date?

Name of Medical Doctor and date of last visit:

PRESENT HEALTH COMPLAINTS / CONCERNS:

Major

Minor

When did this problem begin?

Is this problem:

☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does this problem radiate?

Yes ☐ No ☐

If yes, where?

What makes this worse?

What makes this better?

Yes ☐ No ☐

If yes, when?

Does this interfere with the child's (check)?

☐ Sleep ☐ Eating ☐ Daily routine

Is this becoming worse?

Other professionals seen for this condition?

Results with that treatment?

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had or has any of the following):

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Irritability
- ☐ Depression
- ☐ Loss of balance
- ☐ Loss of concentration
- ☐ Loss of memory
- ☐ Ears buzzing
- ☐ Poor coordination
- ☐ Vision changes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Light sensitivity
- ☐ Face flushed
- ☐ Cold sweats
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Urinary problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight loss
- ☐ Weight gain
- ☐ Dental problems
- ☐ Fevers
- ☐ Heart palpitations
- ☐ Chest pressure
- ☐ Breast pain
- ☐ Frequent colds
- ☐ Sinus congestion
- ☐ Sore throats
- ☐ Ear pain/infections
- ☐ Allergies
- ☐ Heartburn
- ☐ Bloating/gas
- ☐ Upper back pain
- ☐ Neck pain
- ☐ Low back pain
- ☐ Radiating pain
- ☐ Stiffness
- ☐ Reduced mobility
- ☐ Numbness in leg(s)
- ☐ Numbness in feet
- ☐ Numbness in (hands)
- ☐ Weakness
- ☐ Muscle cramps
- ☐ Sleeping problems

HISTORY OF BIRTH

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 centre ☐ In a hospital ☐

Was the birth considered?

Medical ☐ Midwife ☐

What was the duration of the labour and birth? (hours)

Was your child born?

Cephalic (head first) ☐ Breech (feet first) ☐

Were there any complications?

Yes ☐ No ☐

If yes, please explain:

Please check any assistance which was used during the birth:

- ☐ Forceps
- ☐ Vacuum
- ☐ extraction C-
- ☐ section
- Episiotomy

Was labour:

Spontaneous ☐ Induced ☐

Were medications or epidurals given to the mother during birth?

Yes ☐ No ☐

If yes, what was given?

APGAR score at birth (/10)

APGAR score after 5 minutes (/10)

GROWTH & DEVELOPM ENT

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:

Hold up head:

Sit alone:

Crawl:

Follow an object

Vocalize:

Teethe

Walk

Do you consider the child's sleeping pattern normal?

Yes ☐ No ☐

If no, please explain:

FAMILY HEALTH HISTORY

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

Mother's family

Father's family

Siblings

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.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.)

Yes ☐ No ☐

Please explain:

Any evidence of birth trauma to the infant? (please check)

- ☐ Bruising
- ☐ Stuck in birth canal
- ☐ Respiratory
- ☐ depression Odd shaped head
- ☐ Fast or excessively long birth
- ☐ Cord around neck

Any falls from couches, beds, change tables, etc?

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 ☐ 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 foods?

Food/Juice intolerance

Yes ☐ No ☐

Type?

During the pregnancy, did the mother smoke?

Yes ☐ No ☐

How much?

During pregnancy, did the mother drink?

Yes ☐ No ☐

How much?

Any illness during the pregnancy?

Yes ☐ No ☐

If yes, please specify:

Any supplements taking during pregnancy?

Yes ☐ No ☐

If yes, please specify:

Any drugs taken during pregnancy?

Yes ☐ No ☐

If yes, please specify:

Any ultrasounds?

Yes ☐ No ☐

How many and reasons for being done?

Any invasive procedures during pregnancy? (ie. amniocentesis, CVS, etc.)?

Yes ☐ No ☐

Please explain

Any pets at home?

Yes ☐ No ☐

If yes, please specify:

Any smokers in the home?

Yes ☐ No ☐

Vaccination history: Vaccinations and age given?

Any negative reactions? (Please specify)

Any antibiotics given? (Reason?)

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation?

Yes ☐ No ☐

If yes, please specify:

Any problems with bonding?

Yes ☐ No ☐

If yes, please specify:

Any behavioural problems?

Yes ☐ No ☐

If yes, please specify:

Any night terrors, sleep walking, difficulty sleeping?

Yes ☐ No ☐

If yes, please specify:

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 at their age?

Yes ☐ No ☐

If no, please specify:

Thank you for completing our Chiropractic Child Health History Questionnaire. If there are any other questions or concerns which you have, you may write them down in the space below.