River Oaks Chiropractic and Wellness Centre

DATE OF INITIAL VISIT:

CHILD'S INFORMATION			
Last Name:	First Name:	Middle Initial:	
Street Address:	City:		
Postal Code:	Home phone number:	Date of Birth: (MM/DD/YYYY):	Sex: ☐ F ☐ M

PRIMARY CONTACT INFORMATION		
Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	

SECONDARY CONTACT INFORMATION		
Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	

OTHER HEALTH CARE PROVIDERS		
1. Name & designation:	2. Name & designation:	3. Name & designation:
Phone number:	Phone number:	Phone number:
Address:	Address:	Address:

Date of last visit to medical doctor:	Have you been to an ND before? ☐ Yes ☐ No
Are you currently under his/her care? ☐ Yes ☐ No	

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON WITHOUT YOUR CONSENT. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

HEALTH HISTORY QUESTIONNAIRE

Please list Health concerns (or reasons for your visit to the clinic) in order of importance to you:

1.
2.
3.
4.

Date of last physical exam:	How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Immunizations:

☐ Tetanus	☐ Smallpox	☐ DPT (diphtheria, polio, tetanus)
☐ Hepatitis A	☐ Tuberculosis	☐ Chickenpox
☐ Hepatitis B	☐ Influenza (flu shot)	☐ MMR (measles, mumps, rubella)

Any adverse reactions?

Childhood illnesses:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ TB ☐ Pneumonia ☐ Scarlet Fever
☐ Jaundice ☐ Diabetes ☐ Asthma ☐ Ear Infection ☐ Whooping Cough ☐ Mono ☐ Impentigo ☐ Eczema ☐ Warts

Please indicate any serious illnesses/conditions/surgeries or reasons for hospitalizations:

Date of diagnosis	Illness/medical condition/surgery/hospitalization	Is the condition still present?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please list any prescribed drugs, over-the-counter medications and supplements, (pain killers, vitamins, herbs, allergy meds etc)

Medication/Supplement	Prescribing Physician	Dosage/day	Date started	Condition it's treating

Has your child taken antibiotics in the last 5 years ? ☐ Yes ☐ No
How many times has your child taken anti-biotics within the last 5 years? For what conditions?

Please list all allergies (medications, foods, supplements, environmental, etc…)

Name of allergen:	Reaction and severity of reaction:

Was the mother exposed to any of the following during her pregnancy:

Alcohol ☐ Yes ☐ No	Tobacco ☐ Yes ☐ No	Prescription Drugs ☐ Yes ☐ No
Radiation/Excessive UV ☐ Yes ☐ No	Recreational Drugs ☐ Yes ☐ No	Chemotherapy ☐ Yes ☐ No
Infectious Disease ☐ Yes ☐ No	Stress ☐ Yes ☐ No	Other: ☐ Yes ☐ No

Any complications during pregnancy?

Gestational diabetes ☐ Yes ☐ No	Eclampsia/Pre-eclampsia ☐ Yes ☐ No	Hemorraging ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No	Thyroid disorders ☐ Yes ☐ No	Other: ☐ Yes ☐ No
How would you rate the mother's health during pregnancy?		☐ Excellent ☐ Good ☐ Fair ☐ Poor
How would you rate the mother's emotional health during pregnancy?		☐ Excellent ☐ Good ☐ Fair ☐ Poor

Time Length

☐ Preterm (<37 weeks) ________ ☐ Term (38-42 Weeks) ________ ☐ Post-Term (>42 weeks) _______	Age of mother at child's birth: ______ Weight at birth: _______

Please check all that apply

☐ Epidural ☐ Forceps	☐ Vaginal birth ☐ C-section birth	☐ Episotomy ☐ Other:

Did the child experience any of the following after birth?

☐ Jaundice ☐ Problems breastfeeding ☐ Congenital birth defects	☐ Colic ☐ Seizures ☐ Deformities	☐ Rashes ☐ Breathing problems ☐ Other
Was your child breastfed? ☐ Yes ☐ No How long? __________	Formula? ☐ Yes ☐ No How long? __________	

Sleep	Hours per day___________ Hours per night __________ Quality of sleep: ☐ Easily aroused ☐ Hard to wake ☐ Nighmares Position: ☐ On back ☐ On stomach ☐ On right side ☐ On left side

Diet	Typical breakfast: Lunch: Dinner: Water: Juice: Soda: Cravings: Aversions:
Social History	Age began sitting: ____ crawling: ____ walking:____ first words: ____ Describe your child's disposition when interacting with other children/care givers/family members: Describe your child's behaviour and performance at school: How would you describe your child's temperament: Is your child physically active? ☐ Yes ☐ No How many hours/day: _____ How many hours of TV/day: _____ hours in front of the computer/day: _____
Environment	How would you describe the emotional climate of the child's home? Are there any pets in the home? ☐ Yes ☐ No What type & how many: ________ Does anyone in the child's house smoke? ☐ Yes ☐ No Is the child exposed to? Asbetos ☐ Yes ☐ No Lead paint ☐ Yes ☐ No Mildew ☐ Yes ☐ No

FAMILY HEALTH HISTORY

INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION (INCLUDING POST-PARTUM) OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER RELEVANT HEALTH PROBLEMS.

	AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER				GRANDMOTHER (maternal)		
MOTHER				GRANDFATHER (maternal)		
SIBLINGS		☐ M ☐ F		GRANDMOTHER (paternal)		
		☐ M ☐ F		GRANDFATHER (paternal)		
		☐ M ☐ F				

☐ I don't know our family history

THANK YOU FOR COMPLETING THE FORM!
IT WILL HELP YOUR DOCTOR GAIN MORE INSIGHT ON YOUR CHILD'S ENTIRE CASE.