CONFIDENTIAL HEALTH HISTORY - CHILD

River Oaks Chiropractic and Wellness Centre

Child's Name: ______________________________ Gender: ◻ M ◻ F D.O.B.: M / D / Y File No.: ________

Parent(s) Name: ______________________________ Sibling(s) Name(s) (Ages): ___________________________

Address: ____ City/Province: __________________ PC __________

Home Phone: ______________________ Email: ______________________________________

Who may we thank for referring you to our office? ____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S):____WORK TEL: _________________

I hereby authorize and consent to the chiropractic evaluation and care of my child, and I have been made aware of what the risks and benefits are for my child to receive chiropractic care.

PARENT/GUARDIAN SIGNATURE: _______________________________________ DATE: M / D / Y

WITNESS SIGNATURE: __________________________________ NAME: ______________________________

Has your child ever received chiropractic care? ◻ N ◻ Y Who? ______________ Last visit: M / D / Y

Name of Medical Doctor: __________________________ Location or Tel. Number? ___________________________

Date of last MD visit and reason: M / D / Y ____

Current Weight: _________ Height: _________ Any recent weight: ◻ Loss ◻ Gain How much? __________

CURRENT HEALTH CONDITION

Current Health Complaint(s): ____

When did this begin? ____

Has the condition occurred before? ◻ Yes ◻ No When? ____

Is the condition: ◻ School/Sport Related ◻ Auto Related ◻ Home Injury ◻ Fall ◻ Other: ________________

What does it feel like: ◻ Sharp ◻ Dull ◻ Ache ◻ Pins & Needles ◻ Numb ◻ Burning ◻ Other: _________

Frequency of Pain: ◻ Constant ◻ Intermittent If intermittent, how often? ____________________________

How long does each episode last? ______________________ When was your last episode? ___________________

Please circle a number below to indicate the severity of your pain:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Has the condition been getting: ◻ Worse ◻ Better ◻ Stayed the Same

What aggravates the condition? ____

What makes the condition feel better? ____

Does your pain radiate anywhere (e.g. into arms or legs)? ◻ Y ◻ N Where? ______________________________

What activities are you unable to do because of this condition? ______________________________________

Have you had any previous injuries to the area of your complaint? ◻ Y ◻ N When? ______________________

Have you seen another health professional for this condition? ◻ Y ◻ N Who? ____________________________

What previous treatments have you received for this condition? _______________________________________

Patient: ________________________
File No.: __________

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has currently or in the past 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 Hand(s)
- ◻ Weakness
- ◻ Muscle Cramps
- ◻ Sleeping Problems
- ◻ Bed Wetting
- ◻ Other: ____

HISTORY OF BIRTH

What was the child's gestational age at birth? ________ Weeks. Birth weight: ____________ Birth length: ____________

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

Was the birth considered: ◻ medical ◻ midwife

What was the duration of the labour and birth? ________ hours

Was child born: ◻ Cephalic (head first) ◻ Breech (feet first) ◻ Cesarean

Were there any complications? ◻ No ◻ Yes, please explain ____

Please check any assistance which was used during the birth: ◻ Forceps ◻ Vacuum Extraction

Was labour: ◻ Spontaneous ◻ Induced

Were medications or epidurals given to the mother during birth? ◻ No ◻ Yes, what was given?______________________

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ◻ Yes ◻ No, please explain ______________________

____

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

Vocalize __________ Sit alone ___________ Teeth _____________

Crawl ___________ Walk _____________

Do you consider the child's sleeping pattern normal? ◻ Yes ◻ No, please explain ___________________________________

____

Has your daughter begun menstruating? ◻ No ◻ Yes, when ________________________

Has your child experienced any other developmental delays/problems? ◻ No ◻ Yes, please explain:____________________

____

Patient: ______________________
File No.: __________

HEALTH HISTORY

Please indicate if your child has had any surgeries/operations/hospitalizations:

□ Appendix □ Tonsils □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones: ______________________

□ Other: ______________________

Does your child have any medical conditions: ______________________

Is your child currently taking any medications or supplements: ______________________

Has your child had any of the following done in the last six months: □ X-ray □ Ultrasound □ MRI □ CT scan

Has your had any blood work done in the last year? □ Y □ N If yes, why? ______________________

Is there any member of your family who has the following:

□ Diabetes □ Cancer □ Arthritis □ Stroke □ Neurological Disorder □ Blood Pressure Problem

□ Heart Problem □ Seizures/Convulsions □ Similar Condition To Your Current Complaint

VACCINATION HISTORY

Vaccinations and age given? ______________________

Any negative reactions? □ No □ Yes, what were they? ______________________

Any antibiotics given? □ No □ Yes, reason? ______________________

PHYSICAL/CHEMICAL 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? (E.g. Falls, accidents, etc.) □ No □ Yes: ______________________

Any evidence of birth trauma to the infant? □ No □ Yes: ______________________

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

Any sports played? ______________________

Is a school backpack used? □ No □ Yes, approximately how much does it weigh? __________

Was this child breast-fed? □ No □ Yes, how long? __________

Formula introduced at what age? __________ What formula? ______________________

Introduction of cow's milk at what age? __________ Began solid foods at what age?______________________

Type of foods first introduced to? ______________________

Food / Juice intolerance? □ No □ Yes, what type? ______________________

During pregnancy, did the mother, smoke? □ No □ Yes, how much? __________

drink? □ No □ Yes, how much? __________

Any illnesses during the pregnancy? □ No □ Yes, what illnesses? ______________________

Any supplements taken during pregnancy? □ No □ Yes, what supplements? ______________________

Any drugs taken during pregnancy? □ No □ Yes, what drugs? ______________________

Any ultrasounds? □ No □ Yes, how many and reasons for being done? ______________________

Any invasive procedures during pregnancy (E.g. Amniocentesis, CVS, etc.)? □ No □ Yes: ______________________

Any pets at home? □ No □ Yes, what kind(s)? ______________________

Any smokers in the home? □ No □ Yes

Patient: ______________________
File No.: _________

Any difficulties with lactation? ☐ No ☐ Yes, what are they? ____

Any problems with bonding? ☐ No ☐ Yes, what are they? ____

Any behavioural problems? ☐ No ☐ Yes, what are they? ____

Any: ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? ____________

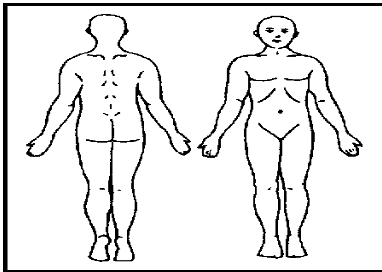
Average number of hours of television per week? ____________

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

PHYSICAL EXAMINATION

Posture/Observation

- ☐ Bruising
- ☐ Swelling
- ☐ Cuts/Scars
- ☐ Rash
- ☐ Other:



Arches: ☐ Low ☐ Normal ☐ High ☐ R ☐ L ☐ B
Head Carriage: ☐ Mild ☐ Mod. ☐ Severe ☐ A ☐ P

Neurological Exam

Reflexes: Upper: Lower:

Motor: Upper: Lower:

Sensory: Light: Sharp / Dull:

Range of Motion

Active/Passive:

Resisted:

Orthopedic Testing

Joint / Muscle Palpation

L R Other:

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
SI

Dx./Ddx.: ____

Treatment:

☐ Spinal Adjustment ☐ Extremity Adjustment ☐ Joint Mobilization ☐ Thumper ☐ Soft Tissue Therapy/Trigger Point Therapy
☐ Ultrasound ☐ IFC ☐ In-office Stretching ☐ Ice or Heat ☐ Home exercises ☐ Home Ice or Heat ☐ Other:

Frequency: ☐ 1x/wk ☐ 2x/wk ☐ 3x/wk ☐ 1x/2wks ☐ 1x/3wks ☐ 1x/month ☐ Other:

Total Tx. Before Re-evaluation: ____________________