DRONYK HEALTH CLINIC

Child History Form

Please fill the following out as completely as possible. If you need assistance, please ask the front desk staff and they will be happy to assist you.

Child's Name: _____ Date: _____

Parent (s) Name: _____

Address: _____City _____ Prov. _____

Postal Code: _____ Home Phone _____ Other Phone ____ _____

Date of Birth: _____ Age: _____ Gender: M ___ F ____

How did you hear about the clinic?_____

Name of Medical Doctor: _____MD phone #_____

Date of last MD visit and reason: _____

Present Health Concerns:

List the main reason for coming to the clinic. Please record when this concern first started, whether it is constant or intermittent, if anything makes it better or worse, treatments/therapies you have tried, and any other details you feel are pertinent.

_____

_____

_____

_____

List any other health concerns;_____

_____

Please check if your child has or has had any of the following:

□ Headaches	□ Loss of taste	□ Abnormal weight gain	□ Upper back pain
□Dizziness	□ Sensitivity to light	□ Dental problems	□ Neck pain
□ Fainting	□ Face flushed	□ Fevers	□ Low back pain
□ Fatigue	□ Cold sweats	□ Heart palpitations	□ Radiating pain
□ Irritability	□ Bronchitis	□ Chest pressure	□ Stiffness
□ Depression	□ Pneumonia	□ Breast pain	□ Reduced mobility
□ Loss of balance	□ Difficulty breathing	□ Frequent colds	□ Numbness in legs
□ Loss of concentration	□ Shortness of breath	□ Sinus congestion	□ Numbness in feet

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□ Loss of memory	□ Asthma	□ Sore throats	□ Numbness in hands
□ Ears buzzing	□ Urinary problems	□ Ear pain/infections	□ Weakness
□ Poor coordination	□ Constipation	□ Allergies	□ Muscle cramps
□ Vision changes	□ Diarrhea	□ Heartburn	□ Sleeping problems
□ Loss of smell	□ Weight loss	□ Bloating/gas	□ Other:_____

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

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

Was the child born □ cephalic (head first) □ breech (feet first)

Were there any complications? □ yes □ no If yes, please explain_____

_____

Please check any assistance that was used during the birth: □forceps □vacuum extraction □c-section □episiotomy

Was the labour: □ spontaneous □ induced

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? □ yes □ no

Do you consider your child's sleeping pattern normal? □ yes □ no

Did your child hit his/her growth milestones at the right age? ie. Hold head up, crawl, vocalize □ yes □ no

If no, which ones were delayed? _____

Family Health History

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

Mother's family: _____

Father's family: _____

Siblings of the child: _____

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Physical Stressors

Any falls from couches, beds, change tables, etc.? □ yes □ no

Any traumas resulting in bruises, cuts, stitches, or fractures? □ yes □ no

Any hospitalizations or surgeries? □ yes □ no If yes, please explain _____

Is a school backpack used? □ yes □ no

Any sports played?_____

Chemical Stressors

Was the child breastfed? □ yes □ no If yes, for how long? _____

Began solid foods at what age? _____

Food intolerances? _____

Any illnesses during the pregnancy? _____

Any drugs taken during the pregnancy? If yes, which ones?_____

Any invasive procedures during pregnancy? _____

Any pets at home? If yes, what kind? _____

Any smokers in the home? □ yes □ no

Vaccination History

Did your child receive the regular childhood vaccine schedule? □ yes □ no

If no, any vaccines? □ yes □ no If yes, which ones? _____

Any other vaccines? (ie. Influenza vaccine) _____

Any negative reactions to vaccines? □ yes □ no If yes, what were they? _____

Psychosocial Stressors

Any problems with bonding? □ yes □ no

Any behavioural problems? □ yes □ no

Any □ night terrors □ sleep walking □ difficulty sleeping

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 If no, explain:

_____

Medications, Supplements, Allergies

Please list the medications your child is on (or has been on in the past)_____

_____

Supplements your child is on: _____

_____

Does your child have any allergies? _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____TEL: _____

I hereby authorize and consent to the evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

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.

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