



### 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:

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

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Loss of memory    | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Sore throats        | <input type="checkbox"/> Numbness in hands |
| <input type="checkbox"/> Ears buzzing      | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Ear pain/infections | <input type="checkbox"/> Weakness          |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Muscle cramps     |
| <input type="checkbox"/> Vision changes    | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Loss of smell     | <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Bloating/gas        | <input type="checkbox"/> 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: \_\_\_\_\_

**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.

