Seeley's Bay Family Chiropractic

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CONFIDENTIAL CHILD INFORMATION (under 10years)

Name: _____ Date: _____

Parents/Guardian Name: _____

Phone: Res: _____ Bus: _____ Cell: _____

Email: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: (mm/dd/yyyy) _____ Age: _____ Weight: _____ Height: _____

Family Physician: _____ Health Card# _____ Version Code: _____

Who may we Thank for referring you to your office? _____

Is you child receiving care from any other health professional? Y / N

If YES, please name then and their specialty. _____

Please list any drugs/medications/vitamins/other that your child is taking:

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor? _____

_____

When did this condition first begin: _____

Has your child ever received care for this condition before? Y / N

If so, please explain. _____

Is this condition; __Getting worse __Improving __Intermittent __Constant __Unsure

What makes it better? _____

What makes the problem worse? _____

Health Goals for your Child

What are your top three health goals for your child?	**What would you like to gain from chiropractic care?**
1. _____	__Resolve existing condition
2. _____	__Overall wellness
3. _____	__Both

Have you ever visited a chiropractor? Y / N If yes, what is their name? _____

What is their specialty? __Pain Relief __Physical Therapy/Rehab __Nutrition __Subluxation based __Other

Pregnancy & Fertility History

Any fertility issues?	Y / N	If yes, please explain: _____
Did mother smoke?	Y / N	If yes, how many per week? _____
Did mother drink?	Y / N	If yes, how many per week? _____
Did mother exercise?	Y / N	If yes, please explain: _____
Was mother ill?	Y / N	If yes, please explain: _____
Any ultrasounds?	Y / N	If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labour & Delivery History

Child's birth was: __Natural Vaginal Birth __Scheduled c-section __Emergency c-section At how many weeks was delivery? ___

Child's birth was: __At home __At a birthing center __At a hospital __Other Doctor/Obstetrician's Name: _____

Please check any applicable interventions or complications:

__Breech __Induction __Pain Meds __Epidural __Episiotomy __Vacuum extraction __Forceps __Other

Please describe any other concerns or notable remarks about your child's labor/delivery.

Child's birth weight_____ Child's birth height_____ APGAR score_____ APGAR score after 5 minutes_____

Growth & Development History

Is/was your child breastfed? Y/ N If yes, for how long?___ Difficulty with breastfeeding? Y / N

Did they ever use formula? Y / N If yes, at what age?___ If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation? Y / N

If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, growing pains or bang their head? Y / N

If yes, please explain: _____

At what age did your child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____

Teeth:_____ Sit along:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerances or allergies and when they began: _____

_____

Please list any hospitalizations and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in their lifetime and the year: _____

_____

Have you chosen to vaccinate your child? Y / N __On schedule __On a delayed or selective schedule

If yes, please list any vaccination reactions: _____

Has your child received any antibiotics? Y / N

If yes, how many times and list reason: _____

Night terrors or difficulty sleeping? Y / N If yes, please explain: _____

Behaviour, social or emotional issues? Y / N If yes, please explain: _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet? __Mostly whole organic food __Pretty average __High amount of processed food

Family History

Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
1.		
2.		
3.		

Acknowledgement & Consent

Parent/Guardian Signature: _____ Date: _____