Dr. Carolyn Wood & Dr. Samantha Clark **www.clintonchiropractic.ca**
Clinton Chiropractic & Wellness Centre
160 Huron Street, P.O.Box 358, Clinton, ON N0M 1L0
519-482-3481 Fax 519-482-3103

Confidential Child (0-13 years) History Form

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favorably with another health care provider, we will be happy to refer you. If you need help with form, please do not hesitate to ask one of our Chiropractic Health Assistants.
THANK YOU.

Personal Information Date _____

Childs Name _____ Gender ☐ M ☐ F

Mother _____ Father_____

Siblings Names & Ages_____

Date of Birth D_____ M _____ Y _____ Age _____ Contact email_____

Address_____

City/Prov _____ Postal Code _____

Home Phone _____ Best time to reach you at home? _____

Parent's Business/Employer _____ Business phone _____

May we call you at work? ☐ No ☐ Yes Best time to reach you: _____

Referrals are our highest form of compliment; please share with us where you heard about our office:

☐ Parent is a Patient
☐ Yellow Pages
☐ Current patient - who? _____
☐ Other - please specify _____

Please check the phrase that most represents your reason for care:

☐ Wellness ☐ Prevention ☐ Feel good ☐Symptom Relief

Current Health Information

If this child has no complaints and this exam is for a spinal check-up, please skip to section marked with

Current complaint(s) _____

Other doctors/therapists seen for this condition? ☐ No ☐ Yes Who? _____

When did this condition begin? _____ Has this occurred before? ☐ No ☐ Yes

What aggravates this child's condition(s)? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting
☐ Walking ☐ Sleeping ☐ Other _____

What relieves this child's condition? ☐ Ice ☐ Heat ☐ Massage ☐ Stretches
☐ Bed Rest ☐ Walking ☐ Medication
☐ Other _____

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Is this condition becoming ☐ Worse ☐ Better ☐ Constant ☐ Comes & Goes

How does this condition affect this child's:

Ability to sleep? _____

Ability to eat? _____

Behaviour? _____

Ability to play? _____

Name of this child's Medical Doctor/Town _____

Date of last physical examination _____

Does this child currently take any medications? ☐ No ☐ Yes _____

Does this child currently take any natural supplements ☐ No ☐ Multivitamins ☐ Other _____

Is this child currently breastfeeding? ☐ Yes ☐ No If No, when was formula, if ever, introduced? _____

What is your personal satisfaction with this child's diet?

☐ Highly Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Highly Dissatisfied Why? _____

Please indicate with an X under the appropriate frequency of how often this child consumes the following foods:

	3+ times per day	1-2 times per day	3-6 times per day	1-2 times per week	1-2 times per month	Rarely	Never
Fruit							
Vegetables							
Protein Foods							
Processed Food							
Snacks with Sugar							
Chips							
Pop							
Juice with Sugar							
Coffee							
Tea							
Over the Counter Drugs							

Is this child currently involved with any sports or physical activities ☐ No ☐ Yes_____

Please rate the quality of this child's sleep: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Number of sleeping hours at night: _____ Number of napping hours during the day: _____

Does this child suffer from any other health conditions? ☐ No ☐ Yes _____

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Past Health History

Please describe any previous traumas and years:

☐ Motor Vehicle Accidents _____ ☐ Sports injuries _____
☐ Childhood traumas / falls_____ ☐ Birth injuries _____
☐ Concussion/ Knocked Unconscious _____

Has this child ever been to a Chiropractor before? ☐ No ☐ Yes

Name of Previous Chiropractor & City _____
Approximate Date of Last Visit: _____

Were x-rays taken? ☐ No ☐ Yes Of what area(s) _____

Has this child ever had any x-rays taken? ☐ No ☐ Yes Of what area(s)? _____

Has this child ever been hospitalized or had any surgical operations? ☐ No ☐ Yes _____

Has this child ever been prescribed antibiotics? ☐ No ☐ Yes Approximate dates and reasons _____

_____

Has this child ever been prescribed any other medications ☐ No ☐ Yes _____

_____

Vaccination History:
☐ I have chosen not to vaccinate this child ☐ I have not decided yet ☐ Full schedule suggested by my doctor

Have you chosen any additional vaccines for this child? ☐ No ☐ Chicken Pox ☐ Flu Vaccine ☐ Other _____

Have you chosen to opt out of any vaccines for any reason? _____

Has your child ever had any side effects to any vaccines? ☐ No ☐ Yes

If yes, please give dates, vaccine type, and side effects: _____

Family Health History

Is there a family history of any of the following conditions?

☐ Obesity ☐ Allergies ☐ Heart Disease ☐ Arthritis ☐ Osteoporosis ☐ Cancer

☐ Diabetes ☐ Other _____

Thank you for your patience and cooperation in completely filling out this form. The details allow us to perform a specific physical examination and monitor your progress through the stages of care. If you have any questions please feel free to ask.

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The following is list of conditions which may seem unrelated to this child's current complaint. However, we would like to assess this child's full health picture, and some of these conditions can also affect or be affected by his/her overall course of care. Please check if this child currently has or within the past 1 -2 years has had any of the following:

Musculoskeletal
☐ Low back pain
☐ Pain between shoulders
☐ Neck pain
☐ Headaches
☐ Arm pain
☐ Leg pain
☐ Jaw pain/clicking
☐ Growing Pains
☐ Scoliosis

Cardiovascular/Respiratory
☐ shortness of breath
☐ irregular heartbeat
☐ heart problems
☐ pneumonia
☐ bronchitis
☐ asthma

Gastro-Intestinal
☐ Poor appetite
☐ excessive thirst
☐ frequent nausea
☐ diarrhea
☐ constipation
☐ bloating/gas
☐ abdominal cramps
☐ heartburn
☐ reflux
☐ bedwetting

General
☐ fatigue
☐ irritability
☐ allergies
☐ poor sleep
☐ poor balance
☐ poor concentration
☐ high stress
☐ Fever
☐ Frequent colds
☐ difficulty breastfeeding

Nervous system
☐ Fainting
☐ Convulsions
☐ ADD/ADHD
☐ Colic

Eyes/Ear/Nose/Throat
☐ vision problems
☐ loss of smell
☐ dental problems
☐ sore throat
☐ earache/infection
☐ hearing loss
☐ sinus congestion

History of Birth

Birth Weight: _____ Birth Length: _____
Arrival Time: ☐ Premature _____ wks ☐ Term (approx. 40 wks) ☐ Post-term _____ wks
Position at birth: ☐ Vertex (head down) ☐ Breech ☐ Posterior (face-up) ☐ Transverse ☐ Face/Brow
Was labour: ☐ Spontaneous or ☐ Induced ☐ Membranes ruptured ☐ Cervical gel ☐ Pitocin
☐ Other _____
Intervention used: ☐ Forceps ☐ Vacuum Extraction ☐ Manual Pulling by Doctor ☐ Epidural ☐ None
Type of Birth: ☐ Vaginal ☐ C-Section
Duration of Labour: _____
Location ☐ Home ☐ Hospital
Apgar Scores (if known) _____ _____
At birth, was there presence of Jaundice (yellow)☐ No ☐ Yes Cyanosis (blue) ☐ No ☐ Yes
Congenital anomalies/defects ☐ No ☐ Yes Please explain _____
Any problems during pregnancy with this child? ☐ Fall onto buttocks ☐ Low back pain ☐ Gestational diabetes
☐ Hypertension ☐ Other _____
At what age did this child: Hold up head _____ Sit alone _____
Crawl _____ Stand _____
Walk alone _____

Patient Name _____