Child Health History Form

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Personal Information

Child's Name: ____ Date: __________________

Child's Age: ____________ Birth date: __________________ Sex: ❑ M ❑ F

Parent(s) Name: Mother _______________________________ Father ____________________________

Sibling(s) Name(s) & Age(s):____________________, ______________________, ________________

Address:___________________________________ City: _________________ Zip Code:_________

Home Phone:______________________________ Other Number:________________________________

E-mail____________________________________

Who may we thank for referring you? ____

Family doctor's name: ___________________________ Address:________________________________

Has your child ever received chiropractic care? ❑ Yes ❑ No

If yes, who is your child's previous Doctor of Chiropractic?: ____

The date of last visit: ____

The reason for the last visit: ____

Other professionals seen for this: ____

Results with that treatment? ____

Recent tests done (list date beside): ❑ Bloodwork __________ ❑ Urine __________ ❑ XRays_____________

Please indicate the purpose for your child's visit:

❑ Symptom management ❑ Early detection of problems ❑ Prevention ❑ Improved function

❑ Maximizing normal growth and development ❑ Managing developmental delay(s)

❑ Other: _____________________________________

Authorization for Care of a Minor (under 18 years)

Parent(s) Name: ____________________________ Work Telephone:___________________________

I hereby authorize and consent Dr. Seán Manning to administer care as deemed necessary to my child.

Parent/Guardian Signature:____

Date: _______________________________ Witness:____

Present Health Concerns

____

When did this problem begin?____

Is this problem: ❑ occasional ❑ frequent ❑ constant ❑ intermittent

Does problem radiate (go anywhere)? ❑*Yes* ❑*No* If Yes, where? ______________________________

What makes this worse? ____

What makes this better? ____

Is the problem worse during a certain time of the day? ❑*Yes* ❑*No*

If Yes, when? ____

Does this interfere with the child's: ❑Sleep ❑Eating ❑Daily routine ❑Other______________________

Often seemingly unrelated symptoms can manifest as other health concerns. Please indicate if your child has had any of the following:

❑headaches ❑chest pressure ❑weight loss ❑dizziness ❑loss of balance

❑weight gain ❑irritability ❑frequent colds ❑dental problems ❑fatigue

❑fevers ❑depression ❑sore throats ❑heart palpitations ❑sinus congestion

❑asthma ❑fainting ❑cold sweats ❑bronchitis ❑loss of concentration

❑weakness ❑heartburn ❑pneumonia ❑muscle cramps ❑numbness in hand(s)

❑loss of taste ❑poor coordination ❑ears buzzing ❑vision changes ❑difficulty breathing

❑neck pain ❑upper back pain ❑loss of memory ❑shortness of breath ❑loss of smell

❑allergies ❑low back pain ❑constipation ❑radiating pain ❑light sensitivity

❑diarrhea ❑sleeping problems ❑face flushed ❑urinary problems ❑numbness in leg(s)

❑stiffness ❑reduced mobility ❑bloating/gas ❑numbness in feet ❑ear pain/infections

❑Other:____

Birth History

What was the child's gestational age at birth? ____ weeks Duration of birth: ____________ hours

Birth weight ________lbs _______oz Birth length ________ inches Head circumference __________ centimeters

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

Birth care provider's name:_______________________________________ ❑OB/GYN ❑Midwife ❑Other_______

Was child born: ❑cephalic (head first) ❑breech (feet first)

Were there any complications? ❑*Yes* ❑*No* If Yes, please explain _______________________________

Assistances used during delivery: ❑ Forceps ❑Vacuum extraction ❑C-section ❑Episiotomy

Was labor: ❑Spontaneous ❑Induced ❑Scheduled C-section ❑Emergency C-section

Birth History (continued)

Were medications or epidurals given to the mother during birth? ❑ *Yes* ❑ *No* If Yes, please explain __________

APGAR score: at Birth _____/10 After 5 minutes___/10

Interventions immediately after birth: ❑ Vitamin K ❑Antibiotics ❑Silver Nitrate ❑Hepatitis B ❑Other______

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? ❑ *Yes* ❑ *No*

If no, please explain ____

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

Vocalize _____ Sit alone _____ Teethe _____ Crawl _____ Walk _____

Does your child sleep: ❑front ❑back ❑side

Do you consider the child's sleeping pattern normal? ❑ *Yes* ❑ *No* How many hours per day? ______________

If no, please explain ____

Family Health History

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

Mother's family ____

Father's family ____

Siblings ____

Physical Stressors

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ❑ *Yes* ❑ *No*

If yes, please explain ____

Any evidence of birth trauma to the infant?

❑ *bruising* ❑ *odd shaped head* ❑ *stuck in birth canal* ❑ *cord around neck*

❑ *fast or excessively long birth* ❑ *respiratory depression* ❑ *torticollis*

Any falls from couches, beds, change tables, etc? ❑ *Yes* ❑ *No*

If yes, please explain ____

Any traumas resulting in bruises, cuts, stitches or fractures? ❑ *Yes* ❑ *No*

If yes, please explain ____

Any hospitalizations or surgeries? ❑ *Yes* ❑ *No*

If yes, please explain ____

Any sports played? ____

Is a school backpack used? ❑ *Yes* ❑ *No* Is it ❑heavy or ❑light?

Chemical Stressors

Was this child breast-fed? ❑ *Yes* ❑ *No* If yes, how long: ___________________________________

Formula introduced at what age: __________ Which formula? ____________________________

Chemical Stressors (continued)

Introduction of cow's milk at what age: _______________ Began solid foods at what age: _________________

Types of solid foods:____

Food/Juice intolerance? ❑ *Yes* ❑ *No* Type: ____

Is your child on or has taken any medications (antibiotics, etc.)? ❑ *Yes* ❑ *No* Type: ________________________

Any pets at home? ❑ *Yes* ❑ *No* ____

Any smokers in the home? ❑ *Yes* ❑ *No*

Any antibiotics given? ❑ *Yes* ❑ *No* If yes, reason: ____

During the mother's pregnancy:

Did the mother smoke? ❑ *Yes* ❑ *No* How much? ____

Drink alcohol? ❑ *Yes* ❑ *No* How much? ____

Any illnesses during the pregnancy? ❑ *Yes* ❑ *No* If yes, describe:______________________________________

Any supplements taken during pregnancy? ❑ *Yes* ❑ *No* If yes, describe:_________________________________

Any drugs taken during pregnancy? ❑ *Yes* ❑ *No* ____

Any ultrasounds? ❑ *Yes* ❑ *No* How many:____________ Reasons for being done:_________________________

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ❑ *Yes* ❑ *No* ____________________

If yes, please explain ____

Psychosocial Stressors

Any difficulties with lactation? ❑ *Yes* ❑ *No* ____

Any problems with bonding? ❑ *Yes* ❑ *No*____

Any behavioral problems? ❑ *Yes* ❑ *No*____

Any trouble at school? ❑ *Yes* ❑ *No*____

Any difficulty making friends? ❑ *Yes* ❑ *No*____

Any night terrors, sleep walking, difficulty sleeping? ❑ *Yes* ❑ *No*_____________________________________

Age of child when 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? ❑ *Yes* ❑ *No*

____

Thank you for completing this form. If you have any other questions or concerns, please write them below.

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Doctor's Notes:

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