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 Names & Ages:______________________, _________________________, _________________________

Address:____ City: ___________________ Zip Code:__________

Home Phone:__________________________________ Other Number:____________________________________

Parent/Guardian's Email:____

Family doctor's name: _______________________________ Address:_____________________________________

Who may we thank for referring you? ____

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 condition: ____

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 & 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

List concern(s):____

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	☐ Breast Pain
☐Weight Gain	☐Irritability	☐Frequent Colds	☐Dental Problems	☐ Loss of Taste
☐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)
☐Fatigue	☐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
☐Loss of Balance				

☐Other: ____

Birth History

Child's gestational age at birth? (wks): _______ Duration of Birth (hrs):_______

Birth Weight: _____lbs _______oz Birth Length (in):________ Head Circumference (cm):________

Was your child's birth at: ☐ Home ☐ Birthing Center ☐Hospital

Was your 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

Were medications or epidurals given to the mother during birth? ☐*Yes* ☐*No* If Yes, 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 _____

How 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) present in:

Mothers family ____

Fathers family ____

Siblings ____

Physical Stressors

Any traumas to the mother during pregnancy? (i.e. 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

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? ☐ Light?

Chemical Stressors

Was your child breast-fed? ☐*Yes* ☐*No* If yes, how long: ____

Formula introduced at what age: __________ Which formula? _______________________________________

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 taking or have they taken any medications? (i.e. antibiotics) ______________________________

<u>During the mother's pregnancy</u>:

Did the mother smoke? ☐*Yes* ☐*No* If yes, how much? ____

Drink alcohol? ☐*Yes* ☐*No* If yes, 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 (i.e. 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 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. Please list any additional concerns below.

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Doctor's Notes:

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