taylor creek
CHIROPRACTIC

Pediatric History Form (0-5 years of age)

Please complete the following health questionnaire.

Child's Name: ____________________ Date: ____________
Sibling(s) Name(s) (Ages): ____________________
Address: ____________________ City: ____________ Prov. ________
Postal Code: ________ Phone: ____________ Child attends: ☐Daycare ☐School /grade ________
Date of Birth: ____________ Age: _____ Gender: ☐ M ☐ F Referred by: ____________
Birth Weight: ____________ Birth Length: ____________ Current Weight: ____________
Has your child ever received chiropractic care? ☐Yes ☐No If yes, previous DC's name and last visit date?
____
Name of Medical Doctor: ____________________
Date of last MD visit and reason: ____________________

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name: ____________________ Relationship: ____________ Cell: ____________
Parent/Guardian Name: ____________________ Relationship: ____________ Cell: ____________
I hereby authorize and consent to the chiropractic evaluation and care of my child.
PARENT/GUARDIAN SIGNATURE: ____________________ DATE: ____________
Parent(s)/guardian(s) Email address: ____________________/____________________

Present Health Complaints/Concerns:

Major: ____________________
Minor: ____________________
When did this problem begin? ____________________
Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent
Does problem radiate? ☐ 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?
Is this becoming worse? ____________________
Other professionals seen for this condition? ____________________
Results with that treatment? ____________________
Drugs currently taking: ☐ Inhalers ☐ Antibiotics ☐ Ritalin (or equivalent) ☐ Tylenol/Ibuprofen ☐ Other: ______
Surgery: ☐ Tonsils/ adenoids ☐ Tubes in ears ☐ Hernia ☐ Appendix ☐ Other ____________
Major falls/ trauma: ☐ concussion ☐ broken bone ☐ broke tooth ☐ stitches ☐ sprain/ strain
Have x-rays been taken in the last year? ☐ No ☐ Yes when & which area: ____________________
Has the child ever been in an automobile accident? ____________________
Has the child been to the Emergency Room? ____________________
Has the child ever been hospitalized? ____________________

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Below is a list of questions that may seem unrelated to the purpose of your appointment, however, please answer carefully as these problems can affect the overall course of chiropractic care.

PRENATAL HISTORY

Duration of gestation

- ☐ 40 weeks (9 months)
- ☐ Less than 40 weeks_______
- ☐ Falls/accidents during pregnancy

____

____

Labour/ Delivery

- ☐ Spontaneous Labour
- ☐ Induced Labour
- ☐ Vaginal
- ☐ C-Section
- ☐ Forceps
- ☐ Vacuum Extraction
- ☐ Breech
- ☐ Epidural
- ☐ Fast delivery
- ☐ Excessively long delivery

At birth did your child have

- ☐ Odd shaped head
- ☐ Bruising
- ☐ Respiratory distress
- ☐ Cord Around Neck

____

Feeding history

- ☐ Breast fed_____months
- ☐ Bottle fed _____months
- ☐ Food sensitivities/allergies

____

Hours of sleep________/ night

The child sleeps his:

○ side ○ back ○ stomach

Sleeping concerns:

____

INFANCY TO AGE 2

Has your child ever suffered from:

- ☐ Colic
- ☐ Reflux
- ☐ Recurrent ear infections
- ☐ Recurrent colds/flu
- ☐ Asthma/ Respiratory problems
- ☐ Walking problems
- ☐ Digestive/ Elimination problems
- ☐ Fall from high place (bed, stairs, table, sofa, other…

____

AGE 2 TO PRESENT

Has your child ever suffered from:

- ☐ Neck pain
- ☐ Headaches
- ☐ Ear infections/ pain
- ☐ Recurrent colds/flu
- ☐ Recurrent fevers
- ☐ Sinus congestion
- ☐ Asthma/ Respiratory problems
- ☐ Bronchitis / pneumonia
- ☐ Mid back pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach aches/ bloating
- ☐ Vomiting
- ☐ Hyperactivity
- ☐ Concentration issues
- ☐ Fatigue
- ☐ Fainting
- ☐ Bed wetting
- ☐ Vision changes
- ☐ Arm/ Hand pain
- ☐ Leg/ foot pain
- ☐ Walking problems
- ☐ Muscle cramps
- ☐ Coordination difficulty
- ☐ Learning difficulty

Does / did child ever participate in the following activities:

- ☐ Hockey
- ☐ Football
- ☐ Figure skating
- ☐ Dance
- ☐ Gymnastics
- ☐ Trampoline
- ☐ Horseback riding
- ☐ Soccer
- ☐ Rollerblading
- ☐ Snowboard/downhill skiing
- ☐ ______________________
- ☐ ______________________

DISEASES

- ☐ Measles
- ☐ Mumps
- ☐ Epilepsy/ seizures
- ☐ Whooping cough
- ☐ Asthma
- ☐ Pneumonia / RSV
- ☐ Croup
- ☐ Meningitis
- ☐ Chicken pox
- ☐ Eczema
- ☐ Allergies____________________
- ☐ Other: ______________________

____

TRAUMAS

- ☐ Concussion
- ☐ Broken bone________________
- ☐ Stitches____________________
- ☐ Sprained joint
- ☐ Whiplash
- ☐ Fall from height
- ☐ Car accident
- ☐ Emergency care
- ☐ X-rays/ MRI/ CT scan

Information you believe is important that has not been asked: ____

Parent/ Guardian Signature: ____ Date: _________________________