Chestermere Family Chiropractic
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Chestermere, AB T1X 1M1
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Pediatric Health History

(Please answer all questions, even if they seem unrelated to your child's case)

Name: _____ AHC#_____ Date: _____
Address_____Postal Code_____
Phone # (Home) _____ (Cell) _____ (Work) _____
Email address _____
Birthdate (dd/mm/yyyy) _____ Age _____ Sex_____
Names of parents/guardians _____

Purpose of this appointment? _____
When did this condition begin? _____
Other doctors seen for this condition? No _____ Yes_____
Name(s) and treatment(s) _____
_____
_____
Other Health problems? _____

Check any of the following conditions your child has suffered from during the past 6 months:

___ ear infections	___scoliosis	___seizures	___ chronic colds
___ headaches	___asthma/allergies	___digestive problems	___ ADHD
___ recurring fevers	___colic	___growing/back pains	___ bed wetting
___ car accident	___temper tantrums	other: _____	

_____
Has anyone else in the family had similar issues? No ___ Yes ___
Explain_____
_____

Name of previous Chiropractor: _____Date of last visit: _____
Reason: _____
Name of Pediatrician: _____Date of last visit: _____
Reason: _____
Number of dose of antibiotics your child has taken:
During the past 6 months: _____ Total during his/her lifetime: _____
Vaccination history: _____
_____

Prenatal History:
Name of Obstetrician/Midwife: _____
Complications during pregnancy? ____ No ____ Yes — List: _____
_____
Ultrasounds during pregnancy? ____ No ____ Yes — Number: _____
Medications during pregnancy/delivery? ____ No ____ Yes — List: _____
_____
Cigarette or alcohol use during pregnancy? ____ No ____ Yes
Location of birth? ____ Hospital ____ Birthing Centre ____ Home

Birth interventions: ____ Forceps ____ Vacuum extraction ____ Caesarian section
Complications during delivery? ____ No ____ Yes — Explain: _____
_____
Genetic disorders or disabilities? ____ No ____ Yes — Explain: _____
_____

Feeding history:
Breast fed? ____ No ____ Yes – How long? _____
Formula Fed? ____ No ____ Yes – How long? _____
Introduced solids at _____ months cows' milk at _____ months
Food/juice allergies or intolerances? ____ No ____ Yes — Explain: _____
_____

Developmental History:
At what age was your child able to:
____ Respond to sound ____ Hold head up ____Cross crawl
____ Respond to visual stimuli ____ Sit up ____ Stand alone
____ Walk alone

Has your child ever fallen from a high place during their first year of life (e.g. Bed, change table, down stairs, etc.)? ____ No ____ Yes — Explain: _____
_____
Is/was your child involved in any high impact or contact sports (e.g. soccer, football, gymnastics, etc.)? ____ No ____ Yes — List: _____
_____
Has your child ever been involved in a car accident? ____ No ____ Yes — Explain: _____
_____
Has your child ever been seen on an emergency basis? ____ No ____ Yes — Explain: ___
_____
Any other traumas not described above? ____ No ____ Yes — Explain: _____
_____
Prior Surgeries? ____ No ____ Yes — List: _____
_____
Menstruation? ____ No ____ Yes — Age: _____

Childhood diseases:
Chicken Pox Age: _____ Rubeola Age: _____ Whooping cough Age: _____
Rubella Age: _____ Mumps Age: _____ Other: _____ Age: _____