ROCKWAY CHIROPRACTIC CLINIC

625 King Street East - Unit 1B, Kitchener, Ontario N2G 4V4 Tel: (519) 744-4745 Fax: (519) 744-7120

CHILDREN'S HEALTH HISTORY

Dear New Patient: It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information about your child. We look forward to working with you to build better health for your family. **PLEASE PRINT**

Child's Name: ____________________ Today's Date: ____________

Address: ____________________ City: ____________

Province: ____________ Postal Code: ____________ Home Phone #: ____________

Date of Birth: ____________ Age: ______ Sex: ______ Height: ________ Weight: ________

Referred by: ____________________ Previous Chiropractor: ____________________

Siblings' Names and Ages: ________________________________

Parents' Names: ____________________ Work Phone #: ____________

Name of Family Physician: ____________________ City: ____________

Date of last visit: ____________ Purpose: ____________________

PURPOSE OF THIS VISIT TO OUR CLINIC:

☐ Spinal screening & Wellness care

☐ Accident or Fall *(please specify)*: ____________________

☐ Pain, illness or other health concern *(please specify)*: ____________________

If this visit is due to pain or other symptoms, please answer the following questions to provide us with more detailed information. Otherwise, please skip ahead to the next page.

What is your child feeling? ____________________

How long has s/he had this problem? ____________________

What do you feel caused this problem? ____________________

Has this problem ever occurred before? ☐ Yes ☐ No *If Yes*, when? ____________________

When does your child experience this problem? ☐ All the time ☐ Comes & goes frequently ☐ Infrequent

How often? ____________________ How long does it last? ____________________

What activities or positions aggravate this problem? ____________________

What makes your child feel better? ____________________

Have any other health care practitioners been consulted for this problem? ☐ Yes ☐ No.

If Yes, with whom, and what was done for your child? ____________________

____

Accidents & Injuries

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. bed, changing table, down stairs etc.). Was this the case with your child?

☐ Yes ☐ No *If Yes*, please describe: ____

Has your child ever been involved in any high impact or contact type sports (ie. soccer, football, hockey, gymnastics, baseball, martial arts, etc.)? ☐ Yes ☐ No Please list: ____________________________________

Has your child suffered from any other injuries or falls, or been involved in a motor vehicle accident?

☐ Yes ☐ No *If Yes*, please describe: ____

Has your child ever been hospitalized or treated on an emergency basis? ☐ Yes ☐ No

If Yes, please describe: ____

Prenatal & Infant History

Complications during pregnancy? ☐ Yes ☐ No Please list: ____

Complications during labour/delivery? ☐ Yes ☐ No Please list: ____________________________________

Type of birth: ☐ Vaginal ☐ Forceps ☐ Vacuum extraction ☐ Breech ☐ Cesarean (☐ Planned or ☐ Emergency)

Genetic or congenital disorders? ☐ Yes ☐ No *If Yes*, please list: ____________________________________

Breast fed? ☐ Yes ☐ No How long: __________ Formula fed? ☐ Yes ☐ No How long: __________

General Health History

Check any of the following conditions your child has experienced during their lifetime:

☐ Ear Infections	☐ Scoliosis	☐ Headaches	☐ Dizziness	☐ Back, Neck or "Growing" Pains
☐ Asthma/Allergies	☐ Diabetes	☐ Seizures	☐ Stomach Aches	☐ Numbness or Tingling
☐ Poor Appetite	☐ Diarrhea	☐ Constipation	☐ Temper Tantrums	☐ Digestive Problems
☐ Hyperactivity	☐ Colic	☐ Chronic Colds	☐ Sleeping Problems	☐ Learning Disabilities
☐ Bed Wetting	☐ Fatigue	☐ Recurring Fevers	☐ Other: ______________________________	

Pertinent family health history: ____

Number of doses of *antibiotics* your child has taken:

During the past six months: __________ , Total during his/her lifetime: __________

Number of doses of *other prescription medications* your child has taken:

During the past six months: __________ , Total during his/her lifetime: __________

Please list the medications: ____

Has your child had any of the following illnesses?

☐ Measles (Rubeola) ________ ☐ Mumps ________ ☐ Rubella (German Measles) ________

☐ Pertussis (Whooping Cough) ________ ☐ Chicken pox ________ ☐ Other ________________________

Childhood vaccinations are an optional, yet widely utilized form of disease prevention. As a parent, the decision to vaccinate your children is yours to make. Has your child been vaccinated? ☐ Yes ☐ No

Does your child consume any foods containing: ☐ Caffeine ☐ Artificial sweeteners (i.e. aspartame / nutrasweet)

Food / juice allergies or intolerances? ☐ Yes ☐ No Please list: ____________________________________

For girls only: Menarche *(onset of first menstrual period)*? ☐ Yes ☐ No *If Yes*, age of onset: ________

Signature of Parent or Guardian: ____________________________________ ***Date:*** ____________________