ROCKWAY CHIROPRACTIC CLINIC

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

PEDIATRIC 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 #: _____

PURPOSE OF THIS VISIT TO OUR CLINIC:

□ Spinal screening & Wellness care

□ Accident or Fall *(please specify):* _____

□ Pain, illness or other health concern *(please specify):* _____

Have any other health care practitioners been consulted for this reason? □ Yes □ No.

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

_____

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: _____

Name of Family Physician: _____ City: _____

Date of last visit: _____ Purpose: _____

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

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

Please list the medications: _____

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

PRENATAL HISTORY

Name of Obstetrician / Midwife: _____ City: _____

Ultrasounds during pregnancy? □ Yes □ No How many? _____ Purpose? _____

Was there any *smoking or alcohol consumption* during pregnancy? □ Yes □ No How much? _____

Medications during pregnancy or labour/delivery? □ Yes □ No Please list: _____

Complications during pregnancy? □ Yes □ No Please list: _____

Complications during labour/delivery? □ Yes □ No Please list: _____

Location of birth: □ Hospital □ Birthing Centre □ Home □ Other: _____

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

Was an *epidural* given? □ Yes □ No Child's birth weight: _____ Birth length: _____

Genetic or congenital disorders? □ Yes □ No *If Yes*, please list: _____

FEEDING HISTORY

Breast fed? □ Yes □ No How long: _____ Formula fed? □ Yes □ No How long: _____

Food / juice allergies or intolerances? □ Yes □ No Please list: _____

Introduced to solid foods at _____ months, Cow's milk at _____ months.

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

DEVELOPMENTAL HISTORY

Beginning with a child's birth, there are six critical stages during the baby's growth and development when their spine is especially vulnerable to stress & misalignment and should be examined by a Chiropractor.

If your child is < 2 years old, please indicate which of these important milestones s/he has reached:

☺ Newborn □ Holds head up □ Sits up □ Crawls □ Stands alone □ Walks alone

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 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: _____

CHILDHOOD DISEASES:

Has your child had any of the following illnesses?

□ Measles (Rubeola) _____ □ Mumps _____ □ Rubella (German Measles) _____

□ Pertussis (Whooping Cough) _____ □ Chicken pox _____ □ Other _____

We are here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine your child's results.

Signature of Parent or Guardian: _____ ***Date:*** _____