Care Chiropractic
Health & Rehab

CHILD

3-12 YEARS

Patient Information

Child's Legal Name: _____ Preferred Name: _____ Date: _____

Address: _____City: _____ Postal Code: _____

Mother's Name: _____ Work Phone #: _____ Cell #: _____

Father's Name: _____ Work Phone #: _____ Cell #: _____

Birth Date: D/ ___ M/ ___ Y/ ___ Age: ___ Sex: ❑ M ❑ F Current Weight: _____ Current Height: _____

AHC #: _____ Do you have health care custodial rights? ❑ Yes ❑ No

Primary Complaint/Reason for visit: _____

Lifestyle History

1. What is the child's quality of sleep: ❑ Good ❑ Fair ❑ Poor ❑ Restless
2. Has your family experienced strong emotional distress such as:
   ❑ Separation ❑ Divorce ❑ Loss of a parent ❑ Loss of a sibling ❑ Near fatal disease
   ❑ Recent death of someone close ❑ Strong emotional upset ❑ Other: _____ ❑ None of the above
3. Does your child seem to be developing as you would expect regarding size, strength & co-ordination? ❑ Yes ❑ No
   If no, please explain _____
4. Are there any concerns with the child's diet? ❑ Yes ❑ No
   If yes, please explain _____
5. Are you concerned with any of the following regarding bowel and bladder function?
   ❑ Regularity ❑ Stool consistency ❑ Pain with bowel movements ❑ Bedwetting

Health History

1. Please mark any of the following if they are a concern to you:

❑ Mouth breathing	❑ Recurrent ear infection	❑ Tonsillitis	❑ Tubes in ears
❑ Hoarseness	❑ Recurrent throat infection	❑ Snoring	❑ Difficulty breathing
❑ Sinus infection	❑ Recurrent eye Infection	❑ Adenoids	❑ Watery/Swollen Eyes

2. Please check any occurrence of childhood diseases or conditions:

❑ Chickenpox	❑ Undescended testicles	❑ Thrush	❑ Hernia
❑ Mumps	❑ Measles	❑ Appendix	❑ Rheumatic Fever
❑ Baby Measles	❑ Anemia	❑ German Measles	❑ Other

3. Has this child every suffered from:

❑ Allergies	❑ Rash/dry scaly skin	❑ Colds/flu	❑ Bedwetting
❑ Arthritis	❑ Dizziness	❑ Poor Appetite	❑ Leg problems
❑ Headaches	❑ Ear infections/aches	❑ Heart Trouble	❑ Back/neck problems
❑ Cancer	❑ Hyperactivity	❑ Paralysis	❑ Arm problems
❑ Anemia	❑ Convulsions	❑ Hypertension	❑ Joint problems
❑ Seizures	❑ Asthma	❑ Sinus infections	❑ Chronic ear aches
❑ Diabetes	❑ Neuritis	❑ Dislocation	❑ Broken bones
❑ Tuberculosis	❑ "Growing" Pains	❑ Digestive disorders	❑ Other

4. Is your child currently (or recently) taking any of the following medications? ❑ Yes ❑ No

❑ Anti-inflammatory	❑ Muscle Relaxants	❑ Pain Killer	❑ Antibiotic
❑ Baby Aspirin	❑ Anti-depressant	❑ Steroids	❑ Cortisone
❑ Bronchial Dilators	❑ Benadryl	❑ Others_____	

5. Is your child following an immunization program? ❑ Yes ❑ No

6. Has your child had any reaction to the immunization program? ❑ Yes ❑ No

7. Has your child been examined by an allergist? ❑ Yes ❑ No

8. Is your child having allergy shots? ❑ Yes ❑ No

9. Has your child ever been hospitalized? ❑ Yes ❑ No If yes, why? _____

10. Has your child ever been involved in a motor vehicle accident? ❑ Yes ❑ No

11. Has your child ever received any major trauma? ❑ Yes ❑ No If yes, explain_____

12. Has there ever been a problem in the child's walking? ❑ Yes ❑ No

13. Do you have any concern regarding your child's walking pattern? ❑ Yes ❑ No

❑ Limp	❑ Toe Walking	❑ Scoliosis	❑ Pain
❑ Foot Positioning	❑ Unusual Wear on Shoes	❑ Clumsy	❑Other_____

14. Date of last visit to GP: _____ Name: _____ Purpose: _____

15. Date of last visit to Pediatrician: _____ Name: _____ Purpose: _____

16. Has your child had any reason to see a Dentist? ❑ No ❑ Yes:

Date of Dentist Appt: _____ Name: _____ Purpose: _____

17. Has there been any concerns with vision? ❑ Yes ❑ No If yes_____

18. Have you noted a history of frequent, recurrent swollen lymph nodes? ❑ Yes ❑ No

19. Does your child have a bloated or distended abdomen? ❑ Yes ❑ No

20. Have you noted any changes or difficulty with speech? ❑ Yes ❑ No

21. Are there any hereditary health problems? ❑ Yes ❑ No

22. Has your child been treated on an EMERGENCY basis? ❑ No ❑ Yes: _____

23. Would you describe your child's health as:

❑ Very good ❑ Average ❑ Poor ❑ Sickly

24. Has there been a recent change in your child's energy level? ❑ Yes ❑ No

If yes, is it: Higher ❑ Lower ❑

25. Did your child have prior health problems that they have outgrown/corrected? ❑ Yes ❑ No

If yes, please explain: _____

26. Is there anything else that we should know that has not been addressed? _____

_____

_____

_____

_____ _____ _____

Parent's Printed Name Parent's Signature Date