Pediatric Health History Form

Address: City: Province: Postal Code: Parent's Home Phone: Parent's Home Phone: Parent's Home Phone: Parent's Work Phone: Expiry Date: Parent's and Sibling's Names: Version Code: Expiry Date: Parent's and Sibling's Names: Who may we thank for referring you? Why This Form Is Important: In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Current Health Concern: Health Concern: How often does it occur? When did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How the did it begin? How often does it occur? How ofte	Name:		Date of Birth:		_ Age:	Sex:	M	□F
Health Card Number:	Address:	City:		_ Province:	F	ostal Code: _		
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Brothers:	Family Health History							
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Sisters: Father: Mother:			-					
Mother:								
Mother:	Father:							

In this office we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical*, *chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Boyle Chiropractic and Wellness Centre

Physical Stresses
Any significant falls or trauma to the mother during pregnancy? ☐ Yes ☐ No ☐ Unsure
For the child, were there any falls from couches, beds, change tables, etc? Yes No Unsure
Any hospital visits for concussions, possible fractures or other traumas? ☐ Yes ☐ No ☐ Unsure
Have there been any surgeries? ☐ Yes ☐ No
If yes, please explain:
Is a backpack worn? ☐ Yes ☐ No If yes, is it ☐ heavy or ☐ light?
Does your child participate in sports? ☐ Yes ☐ No
Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)
☐ Yes ☐ No ☐ Unsure
Chemical Stresses
During pregnancy, did the mother: – use medications? ☐ Yes ☐ No If yes, which ones?
- smoke? ☐ Yes ☐ No
– drink? ☐ Yes ☐ No
Was the child breast-fed? ☐ Yes ☐ No If yes, how long?
Formula introduced at what age?
Began solid foods at what age?
Vaccination history: Vaccinations given:
Any reactions? ☐ Yes ☐ No If yes, please list:
Has the child been or is the child currently on any medications? \square Yes \square No
If yes, please list:
Mental/Emotional Stresses
Any problems with bonding? ☐ Yes ☐ No ☐ Unsure
Any behavioural problems? ☐ Yes ☐ No ☐ Unsure
Any night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No ☐ Unsure
Average number of television hours per week?
Do you feel that your child's social and emotional development is appropriate for their age? \square Yes \square No \square Unsure
Authorization For Care of a Minor (Under 16 Years of Age)
I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic staff.
Child's Name: Date: Date:
Parent's Signature: Witness:

Thank you for completing this form. If you have any further concerns, please note them in the space below: