25 Centre St. W | 251 Main St.
Strathroy, On. | Parkhill, On.
N7G 1T5 | N0M 2K0
519-245-0946 | 519-294-0373
Dr. Ron Wagner Bsc., D.C.
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Child History Form

**Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.*

Child's Name____ Todays Date_______________

Date of Birth______________________________

Parent(s) Name____

Siblings Name(s) & Age ____

Address_______________________________________City___________________Prov.___________

Has the child ever received chiropractic care? ***Yes*** ***No***

If yes, name of previous D.C. and date of last

visit?____

Name of Medical Doctor____

Date and reason for last MD visit____

Present Health Complaints/Concerns:

Major____

Minor____

When did this problem begin?____

Is this problem (circle) ***Occasional*** ***Frequent*** ***Constant*** ***Intermittent***

Does the problem radiate? ***Yes*** ***No*** If Yes, where?_________________________________

What makes this worse?____

What makes this better?____

Is the problem worse during a certain time of day? ***Yes*** ***No***

If Yes, when?____

Does this interfere with the child's sleeping?__________ eating?___________ daily routine?__________

Is it becoming worse?____

Other professionals seen for this condition?____

Results with that treatment?____

WAGNER
CHIROPRACTIC HEALTH + WELLNESS CENTRES

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Often seemingly unrelated symptoms can manifest as other health concerns (please check all that apply)

- ○ headaches
- ○ dizziness
- ○ fainting
- ○ fatigue
- ○ irritability
- ○ depressions
- ○ loss of balance
- ○ loss of memory
- ○ loss of concentration
- ○ ears buzzing
- ○ poor coordination
- ○ vision changes
- ○ loss of smell
- ○ loss of taste
- ○ light sensitivity
- ○ face flushed
- ○ cold sweats
- ○ bronchitis
- ○ sore throat
- ○ pneumonia
- ○ difficulty breathing
- ○ shortness of breath
- ○ asthma
- ○ urinary problems
- ○ constipation
- ○ diarrhea
- ○ weight loss
- ○ weight gain
- ○ dental problems
- ○ fevers
- ○ heart palpitations
- ○ chest pain
- ○ breast pain
- ○ frequent colds
- ○ sinus congestion
- ○ sore throat
- ○ ear pain/infections
- ○ allergies
- ○ heartburn
- ○ bloating/gas
- ○ upper back pain
- ○ neck pain
- ○ low back pain
- ○ radiating pain
- ○ stiffness
- ○ reduced mobility
- ○ numbness in leg(s)
- ○ numbness in feet
- ○ numbness in hand(s)
- ○ weakness
- ○ muscle cramps
- ○ sleeping problem
- ○ other ____

History of Birth

What was the child's gestational age at birth? _______ weeks

Birth weight _________lbs_________oz Birth length_________ inches

Was the child born at (circle one) ***Home*** ***Birthing Center*** ***Hospital***

Was the birth considered (circle one) ***Medical*** ***Midwife***

What was the duration of the labour and birth? ___________ hours

Was the child born (circle one) ***Cephalic(head first)*** ***Breech(feet first)***

Were there any complications? ***Yes*** ***No*** If Yes, please explain____________________________

Were any of these used during birth?(circle one) ***Forceps*** ***Vacuum-extraction*** ***C-section*** ***Episiotomy***

Was the labour (circle one) ***Spontaneous*** ***Induced***

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ***Yes*** ***No***

If No, please explain____

What age (months) did your child: Hold head up____ Sit alone____ Teeth____ Crawl____ Walk____

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Do you consider your child's sleeping pattern to be normal? ***Yes*** ***No***

If no, please elxplain____

Family Health History

Please note any family health problems (ie. cancer, diabetes, heart disease, etc.) that are present in:

Mother's family____

Father's family____

Siblings____

**Since problems that chiropractors look for and detect can be related to many types of stressors, the following is also very important to us.*

Physical Stressors

Were there any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ***Yes*** ***No***

If Yes, please explain____

Was there any evidence of birth trauma to the infant? (please check all that apply)

- bruising
- stuck in birth canal
- respiratory depression
- odd shaped head
- fast or excessively long birth
- cord around neck

Any falls from couches, beds, change tables, etc.? ***Yes*** ***No***

If Yes, please explain____

Any hospitalizations or surgeries? ***Yes*** ***No***

If Yes, please explain____

What sports does the child play?____

Is a backpack used for school? ***Yes*** ***No*** Is it(circle one) ***Heavy*** ***Light***

Chemical Stressors

Was the child breast-fed? ***Yes*** ***No*** If Yes, how long?______________________________________

Was formula introduce? ***Yes*** ***No*** At what age?_______ Which formula?______________________

When was cow's milk introduced?___________ When were solid foods introduced?________________

Any food/juice intolerance? ***Yes*** ***No*** Type?____

During pregnancy, did the mother: Smoke? ***Yes*** ***No*** How much?____ Drink? ***Yes*** ***No*** How much?___

Any illnesses during the pregnancy? ***Yes*** ***No*** ____

Any supplements taken during pregnancy? ***Yes*** ***No*** _______________________________________

Any drugs taken during pregnancy? ***Yes*** ***No*** ____

Any ultrasounds? ***Yes*** ***No***____

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Vaccination History

List vaccination and age given____

Any negative reactions? ***Yes*** ***No*** ____

Any antibiotics given? ***Yes*** ***No*** Reason____

Psychosocial Stressors

Any difficulties with lactation? ***Yes*** ***No*** ____

Any problems with bonding? ***Yes*** ***No*** ____

Any behavioural problems? ***Yes*** ***No***____

Any(circle one) ***Night terrors*** ***Sleep walking*** ***Difficulty sleeping***

Age of child when began daycare?____________________

Average number of hours of television per week?_________________

Do you feel that your child's social and emotional development is normal for their age? ***Yes*** ***No***

If No, please explain____