WAGNER
CHIROPRACTIC HEALTH
+ WELLNESS CENTRES

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: ☐ ***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?_____

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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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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
- ☐ other _____

- ☐ 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
- ☐

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: ☐ ***Home*** ☐ ***Birthing Center*** ☐ Hospital

Was the birth considered: ☐ ***Medical*** ☐ ***Midwife***

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

Was the child born***:*** ☐ Cephalic (head first) ☐ ***Breech(feet first)***

Were there any complications? ☐ ***Yes*** ☐ ***No*** If Yes, please explain_____

Were any of these used during birth?: ☐ Forceps ☐ Vacuum-extraction ☐ C-section ☐ ***Episiotomy***

Was the labour: ☐ ***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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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: ☐ ***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_____