Children's Health History

Patient #:_____ Date:_____

Personal Information

Name:_____

How does your child wish to be addressed in our office? _____

Birth Date:_____ ☐ Male ☐ Female

Address: _____

City/Province/Postal Code_____

Guardian's E-mail Address: _____

Father's Name: _____ Father's Phone: _____

Mother's Name: _____ Mother's Phone: _____

Previous Chiropractor/ RMT: _____ Last Visit: _____

How did you hear about our office? _____

Current Health Profile

***If your child currently has no symptoms or complaints please skip to: General Health Profile.**

Health Concerns: List according to Their severity:	**Severity:** 1= mild 10= worst	**When did this episode start?**	**If they've had this condition before, when?**	**Are symptoms constant or intermittent?**
1._____	___	_____	_____	_____
2._____	___	_____	_____	_____
3._____	___	_____	_____	_____
4._____	___	_____	_____	_____

Please briefly describe your child's chief concern, including the effect it has had on their life:

_____

_____

_____ _____

Since the problem started, is it: About the same Getting Better Getting Worse

What makes it worse?_____

What has your child done that has helped them feel better? _____

What has your child done that was of NO help?_____

Other Health Care Professionals seen for this condition:

Name/Profession:	Date:	Diagnosis:	Treatment:	Results:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____

Were x-rays taken? No Yes Area of body:_____ Date: _____

Current Medications & Supplements:_____

General Health Profile

Please indicate all symptoms your child has ever had, even if they do not seem related to their current problem. Use P for Past and C for Current.:

Neck pain	Pins and needles in arms	Low back pain	Allergies
Headaches	Numbness in fingers	Pins and needles in legs	Loss of smell
Lights bother eyes	Shoulder pain	Numbness in toes	Loss of taste
Dizziness	Mid back pain	Loss of balance	Sinus trouble
Fainting	Chest pain	Urinary problem	Fatigue
Loss of concentration	Heartburn	Foot trouble	Cold sweats
Buzzing in ears	Difficulty breathing	Stomach upset	Nervousness
Earache	Sleeping problems	Constipation	Depression
Cold hands	Focus & memory issues	Diarrhea	ADD/ADHD
Tension	Cold feet	Skin conditions	Mood swings
Frequent colds	Leg/foot fain	Anxiety/stress	Hip pain
Nausea	Heart problems	Fever	Tension
TMJ pain/stiffness	Unexplained weight loss	Arm/hand pain	Brain fog
Epilepsy/seizures	High blood pressure	Unexplained weight gain	Joint pain

Females Only: Date of last period: _____

Menstrual Pain	Cramps/backache	Irregular menstruation	Excessive flow
Abnormal discharge	Birth control pill	Intra-uterine device	

Stress Profile

Chronic physical, chemical and emotional stress is the cause of most health problems. Please review these common stresses and circle when your child experienced it in their life. Use P for Past and C for Current. Your answers will help us to determine what contributed to your child's present health.

Physical Stress:		**Explanation:**
1. Forceps, suction extraction, or caesarean delivery	P C	_____
2. Accidents (auto, work related, falls or other)	P C	_____
3. Surgical operations	P C	_____
4. Strains, sprains, and/or broken bones	P C	_____
5. Poor posture (excessive screen use, studying)	P C	_____
6. Poor sleeping habits	P C	_____
7. Sports injuries	P C	_____
8. Overweight	P C	_____
9. Lack of exercise	P C	_____

Chemical Stress:		
1. Take prescription or over-the-counter medication	P C	_____
2. Use tobacco products	P C	_____
3. Use artificial sweeteners (aspartame, sucralose)	P C	_____
4. Poor diet (fast food, white flour, white sugar)	P C	_____
5. Environmental pollution	P C	_____
6. Energy drinks	P C	_____
7. Recreational Drugs	P C	_____

Emotional Stress:		
1. Divorce of parents	P C	_____
2. Death of a loved one	P C	_____
3. Serious illness (self or a loved one)	P C	_____
4. Procrastination	P C	_____
5. Worry and/or fear	P C	_____
6. Relationships	P C	_____
7. Anger by you or at you	P C	_____
8. Low self-esteem	P C	_____

Our goal is to provide the safest and most effective care possible. In order to do so, it is important that we perform a series of tests. I consent to a complete examination for my child as the doctor deems necessary. I understand and agree that I am responsible for payment of all associated fees.

Guardian's Name: _____

Guardian's Signature: _____ Date: _____