SYNERGY Wellness Group

Patient No:

Children's Health History

First name: Last name:

Address: City: Province: Postal code:

Birth date (MM/DD/YYYY): Phone:

Mother's guardian's name: Phone:

Father's guardian's name: Phone:

Who may we thank for referring you to our office?

Reason for contacting our office:

Other professionals seen for this concern:

Please list treatments and results:

Other health concerns:

Family health history:

Previous chiropractor: Date of last visit (MM/DD/YYYY):

Name of pediatrician: Date of last visit (MM/DD/YYYY):

Reason:

Birth History (Please check all that apply)

☐ Hospital ☐ Home birth ☐ Birthing center ☐ Midwife ☐ Vacuum extraction ☐ C-section ☐ Induced

Other complications during birth? ☐ No ☐ Yes

Medications given to mother during labour? ☐ No ☐ Yes

Duration of birth: Hours APGAR at birth: APGAR after 5 minutes:

Was the infant alert and responsive within 12 hours of delivery? ☐ No ☐ Yes If no, please explain below:

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Growth & Development

Any signs that your child is not developing properly? No Yes

Any growing pains? No Yes

How many times has your child been sick in the last year?

Do sleeping patterns seem normal to you?

Chemical Stressors

Please rate on a scale of 1-10 (10 being the best) the mother's diet during pregnancy:

Mother smoked during pregnancy? No Yes Any smokers at home? No Yes

Drugs taken during pregnancy? No Yes If yes, which ones?

Ultrasounds during pregnancy? No Yes If yes, how many?

Was this child breast fed? No Yes If yes, for how long?

Was formula introduced? No Yes If yes, at what age?

Was cow's milk introduced? No Yes If yes, at what age?

Food intolerances? No Yes If yes, which foods?

Number of doses of antibiotics your child has taken:

Other prescription medication your child has taken:

Vaccination history:

Any vaccine reactions? (Please check all that apply):

High pitched screaming Non-stop crying Fever Rashes Hives Convulsions Seizures

Other:

Any digestive problems? No Yes

Any skin problems? No Yes

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Emotional Stressors

Please rate on a scale of 1-10 (10 being the most) the mother's stress during pregnancy:

Was this child allowed to bond immediately after delivery? No Yes

Any behavioural problems? No Yes

Any Night terrors Sleep walking or Difficulty sleeping?

Average number of hours of television/computer/ipad/ipod/video games per week?

Physical Stressors

Any traumas during pregnancy? No Yes

Any evidence of birth trauma? (Please check all that apply):

Bruises Odd shaped head Stuck in birth canal Excessively long birth Respiratory problems

Cord around neck Other:

Any falls from couches, beds, change tables? No Yes

Any traumas with bruising, cuts, stitches, fractures? No Yes

Any hospitalizations? No Yes

Any surgeries or organs removed? No Yes

Sports played and age began?

Weight of school backpack?

Authorization & Consent

I authorize Synergy Wellness Group and their doctors to perform a comprehensive examination of my child's spine and nervous system.

Parent / Guardian's name:

Parent / Guardian's signature:

Date (MM/DD/YYYY):

Witness name:

Witness signature:

Date (MM/DD/YYYY):