new HOPE CHIROPRACTIC

KIDS HEALTH HISTORY FORM

Name:			Date:
Your Mom's Name:		Your Dad's Name:	
Home Address:			Town:
Postal Code:	Parent's Phone:		Email:
BIRTHDAY:	Age:	Gender: ❒ M ❒ F	Who May we Thank for Referring you?
Have you ever received chiropractic care before? ❒ No ❒ Yes Approx Date of Last Visit? Happy with Results? ❒ No ❒ Yes			Brothers? Sister? names & Ages:
School Age Grade:	BC Medical Card # ❒ MSP		Extended Insurance Coverage? ❒No ❒ Yes Name:

Top 7 Reasons Parents take their Child to see a Chiropractor:

Please check reasons for pursuing chiropractic care for your child:

____ To help alleviate aches or pain naturally.
____ To improve spinal posture
____ To maximize brain and nerve development
____ To strengthen immunity and reduce incidence of colds, earaches and general illness
____ To improve child's ability to concentrate.
____ To assist with better sleep
____ To help with colic, asthma or digestive problems.

Prenatal & Birth History

Complications during pregnancy? _____
Complications during delivery? ___Yes ___No If Yes: ___ Forceps ___ Cesarean ___Breech ___Vacuum
__ Mother Induced __Mother medicated (Epidural, Pitocin, etc.) ___Baby given medication
Genetic Disorders or Disabilities? ___Yes ___ No List:_____
Breast Fed: ___Yes ___No How Long?_____ Formula Fed? ___ Yes ____No How Long?_____
Food or Other Allergies? ____Yes ___No List:_____
What was the baby's APGAR Score at 1 minute?_____/10 & at 5 minutes? ____/10 ___ Unsure
Was there initial respiratory delay? ____Yes ___No Purple markings on face? ___Yes ___No
Mis-shaped skull/head? ____Yes ___No

Medical History

Has your child ever been seen in an emergency room? ___Yes _____No List:_____
Any surgeries? ____Yes _____No List:_____
Approximately how many times have antibiotics been prescribed and for what conditions?

_____

List any medications your child is currently taking: _____
Any reactions to any medications, antibiotics or vaccinations? N_____ Yes, if so, describe_____

Current Concerns

Please check if anything currently applies to your child

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains	___OTHER
___ Dizziness	___ Arm/wrist pains	___ Shoulder pains	
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains	
___ Asthma	___ Allergies	___ Growing Pains	
___ Hyperactivity	___ Stomach problems/Reflux	___ Learning Difficulties	
___ Fatigue	___ Constipation/Diarrhea	___ Frequent Colds	

***Which one of the problems from above is the <u>main</u> concern?:**_____

Please circle current levels of function:

1. Sits for duration

Sits in comfort over 30 min	Sits but complains of pain	Sits but moves lots to get comfortable	Cannot sit longer than 10 min	Cannot sit

2. Sleeping

Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturubed sleep	Totally disturbed sleep

3. Behavoir

Even Keeled, happy disposition	Unpredictable but defers to happy disposition	Negative disposition	Outbursts daily throughout day but recovers	Cannot recover from outbursts

4. Focus in school or mental activities

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot focus in school

5. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

6. Digestion

1-2 daily easy BMs	1 BM daily but has to be careful of diet	1 BM daily strained	1 BM every 2nd day but no pain	Pain and daily constipation

7. Energy Level

Even balance energy and alertness	High energy but then drops throughout the day	Needs to rest often in the day	Tired most of the day	Lethargic daily- cannot engage

8. Physical actives

Can do activity for long periods of time	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Consent to evaluation of a minor child

I_____ being the parent or legal guardian of _____

(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation (which may or may not include x-rays) by Dr. Jody Cox or Dr. Ron Pashkewych of New Hope Chiropractic.

_____ _____

Consenting Adult's Signature Date