Child's Health Profile

It is a pleasure to welcome you to our family of happy and healthy practice members. Please complete the following information. We look forward to working with you to achieve better health for your family.

Child Patient Information

Today's Date:_____

Child's Name:_____

Parents' Names: _____

Street Address: _____Apt #_____

City: _____ Prov: _____ Postal Code: _____

Home Phone:_____ Cell: _____

Parent's Work Phone:_____

E-mail:_____

Birth Date (dd-mm-yy): _____ Shoe Size: _____

Height: _____ Weight: _____

Gender: ☐ Male ☐ Female

Parents' Marital Status: ☐Married ☐Common Law ☐Separated ☐Divorced ☐Single

Names, ages and relationship of other children in the home: _____

_____

Who recommended our services to you? _____

Primary Health Concern

What is your child's primary reason for seeking our care? _____

_____

When and how did this challenge to your child's health begin? _____

_____

Was there an injury, trauma or health-significant event that may be a contributing factor?

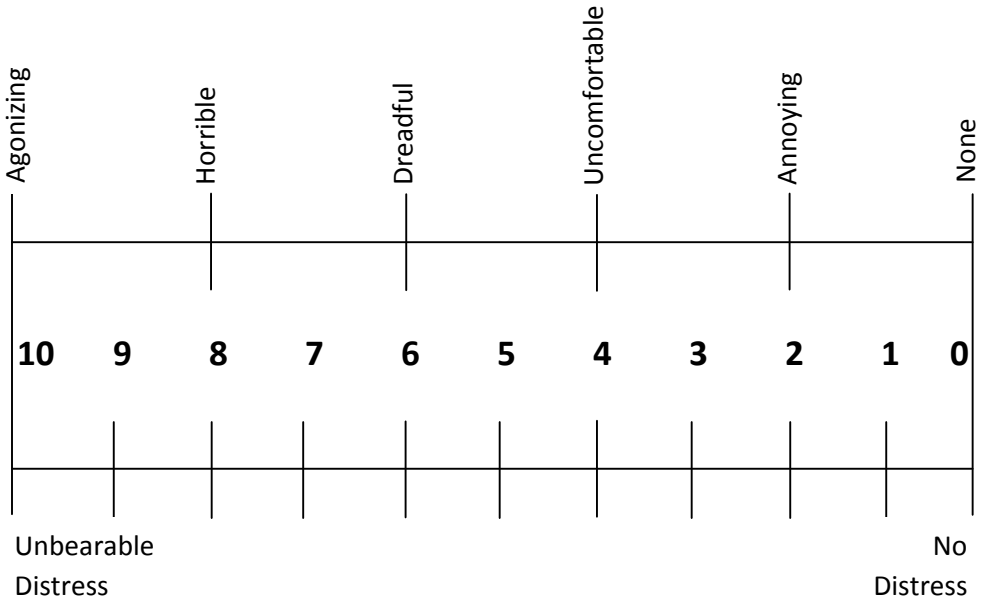
_____

Has your child experienced a similar challenge in the past? _____

Has your child been examined by another practitioner for this? ☐ Yes ☐ No

If so, what was found and/or done? _____

Please indicate below the intensity of any discomfort your child feels now:



Is the area of concern: ☐ getting better ☐ staying the same ☐ getting worse

Why do you think so? _____

What activities, factors or positions aggravate your child's symptoms? _____

_____

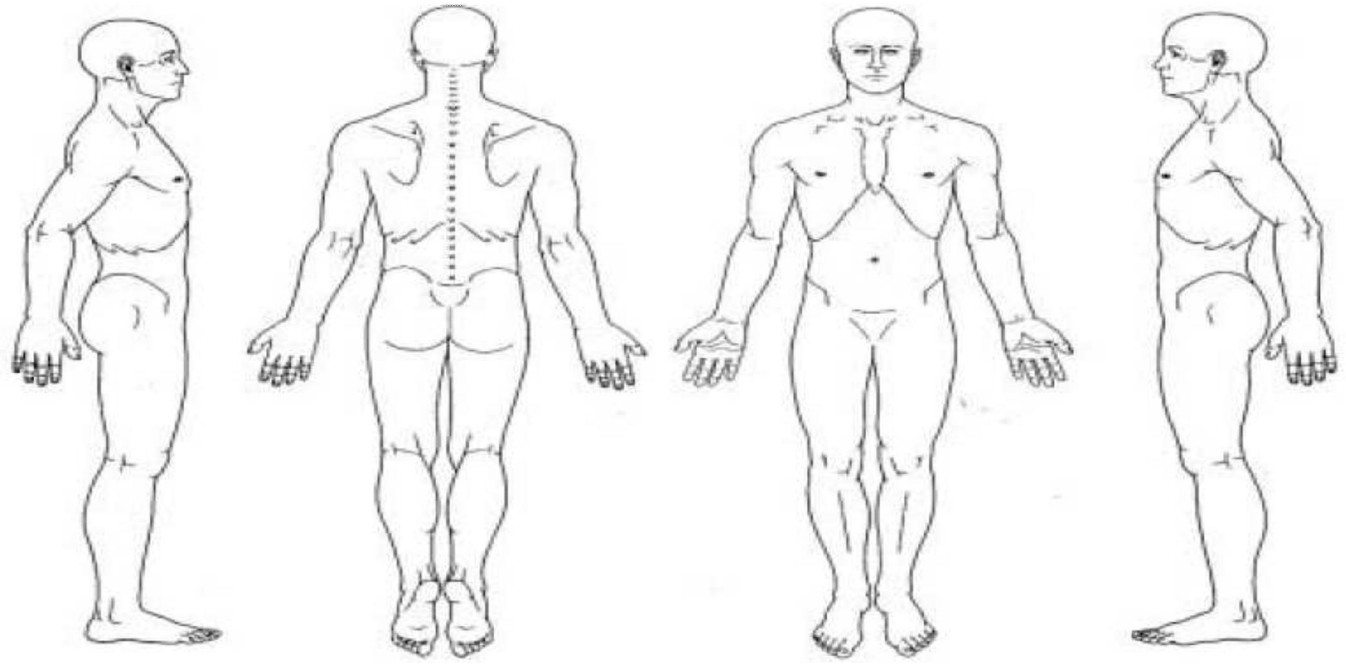
How often does your child experience symptoms? _____

What, if anything, have you found to relieve or improve your child's symptoms? _____

_____

Indicate the areas of discomfort on the diagram by using the following symbols:

Sharp pain XXXXX Dull ache OOOO Numbness …… Tightness //// Tingling ++++



Describe how it feels when symptoms are at their worst: _____

Do your child's symptoms radiate to areas other than the primary area? Where? _____

From 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Lifestyle

Stress Level: ☐Extreme ☐High ☐Moderate ☐Low ☐Absent

Please circle the types of stress that are or have been challenging for your child:

Physical:	Falls	Accidents	Injuries	Repetitive Strain
	Poor Posture	Birth trauma		
Psychosocial:	Loss of loved ones	Move of home	Work/School	Mental, emotional abuse
	Sexual abuse	Family	Financial/Legal	Change in relationship

Chemical: Tobacco Alcohol Coffee/Tea Recreational drugs
Environmental toxins

In what position does your child most commonly sleep? On his/her: ☐ Side ☐ Back ☐ Front

Rate your child's satisfaction with sleep from 1 to 10 (10 being the best sleep): _____

List the forms of exercise and recreational activities in which your child currently participates: _____

_____

Rate your satisfaction with your child's diet from 1 to 10 (10 being very healthy): _____

Health Care History

Date of last: Spinal Examination: _____ Physical examination: _____

Spinal X-Ray: _____ Dental X-Ray: _____

Please list all surgical operations your child has had of any kind, why your child had them, the net result and the approximate dates: _____

_____

Please circle any of the following therapies that your child has had done:

Acupuncture	Chiropractic	Counseling	Dentistry	Homeopathy	Massage
Therapy	Medicine	Naturopathy	Nutrition	Podiatry	Physiotherapy
Reflexology	Reiki	Shiatsu	Traditional Chinese Medicine		

If any of these therapies were of unique value or clearly detrimental, please give details: _____

_____

Please list the medications, prescription and over-the-counter, your child now uses:

_____

Please list the supplements (vitamins, minerals, homeopathic remedies, etc.) your child now uses:

_____

_____

_____

_____

_____

Mainly for Moms

Tell us about your pregnancy:

Were you outwardly ill prior to your pregnancy with this child? ☐Yes ☐No

Were you on any medication during your pregnancy? ☐Yes ☐No

Did you consume alcohol during your pregnancy? ☐Yes ☐No

Did you smoke during your pregnancy? ☐Yes ☐No

Did you have any falls, accidents or injuries during your pregnancy? ☐Yes ☐No

Was the birth traumatic? ☐Yes ☐No

Did you use: ☐ a midwife? ☐ a hospital? ☐ an obstetrician?

How long was the labour? _____

Was the Birth: ☐Drug induced ☐Forceps or vacuum extraction ☐C-section

☐Doctor assisted ☐Cord around the neck ☐Breech

☐Premature ☐Prolonged

In what position did you give birth? _____

Was your child incubated or isolated after birth? ☐Yes ☐No

What was the weight of your child at birth? _____

What was your child's APGAR Score? _____ At 5 minutes? _____

As a baby/toddler (birth to 4 years), did any of the following occur?

☐Fall from a change table ☐Tumble down stairs ☐Fall out of crib

☐Involved in a car accident ☐Fall off playground equipment ☐Play in "Jolly Jumper"

☐Frequent ear infections ☐Tonsillitis ☐Reaction to vaccination

☐Frequent crying spells ☐Frequent fevers ☐Frequent bouts of diarrhea

☐Constipation ☐Sleeping problems ☐Frequent colds

☐Colic ☐Limited weight gain ☐Other_____

Please explain the above: _____

_____

_____

As a young child (5-12 years), did any of the following occur?

☐Fall from a tree	☐Fall off a bicycle	☐Fall off playground equipment
☐Sports accident	☐Stomach pains	☐Scoliosis
☐Bed wetting	☐Hyperactivity/Autism	☐Learning Difficulties
☐Asthma	☐Allergies	☐Leg/knee pains

☐Other _____

Please explain the above: _____

_____

_____

As a child or adolescent, has your child experienced any of the following:

☐Headaches	☐Dizziness	☐Ringing in ears
☐Asthma	☐Hyperactivity	☐Fatigue
☐Numbness in arms/hands	☐Arm/wrist pains	☐Sleeping problems
☐Allergies	☐Stomach problems	☐Weight gain/loss
☐Foot/ankle/knee pains	☐Tingling in arms/legs	☐Neck/back pains
☐Shoulder pains	☐"Growing pains"	☐Other _____

Please explain the above: _____

_____

_____