*Please complete this detailed history form and should you require any assistance, please let us know we would be happy to assist.*

Name:       Phone number:

Address:       Date of birth: Click here to enter a date.

Emergency contact:       Phone number:

Family physician:

Date of last visit & reason:

Present height:      Present weight:

**AUTHORIZATION FOR CARE OF A MINOR**

**I hereby authorize and consent to the chiropractic evaluation and care of my child**

Parent/Guardian signature:       Phone number:

Witness:

Primary complaint:

Reason for contacting us:

List other care undergone for this complaint (including medications):

Date of onset: Click here to enter a date. Onset was:

Duration of problem:  Pattern of problem:

How did it begin:       Aggravating factors:

Relieving factors:

Effects of problems on body function and daily activities:

Any other health concerns:

**HISTORY OF BIRTH**

Where was the child born:

Duration of gestation (weeks):

Assisted birth: Choose an item.

* If yes:  If other, explain:

Medications delivered to mother at birth: Choose an item.

* If yes, explain?

Complications at birth:

* If yes, explain:

Duration of birth:       Was delivery normal:

APGAR at birth:       After 5 minutes:

Birth weight:       Birth length:

**CHEMICAL STRESSORS**

Was the baby breast fed:  How long:

Food/juice intolerance:  Type:

When was the following introduced:

|  |  |
| --- | --- |
| Formula [ ]  | Type:       |
| Cow’s milk [ ]  | Type:       |
| Solid food [ ]  | Type:       |
| Commercial baby food [ ]  | Type:       |

During pregnancy, did mother:

|  |  |
| --- | --- |
| Smoke [ ]  |  |
| Drink alcohol [ ]  |  |
| Have any illness [ ]  | Type:       |
| Take supplements [ ]  | Type:       |
| Take drugs [ ]  | Type:       |
| Folic acid supplementation during conception [ ]   |  |

Was there any:

|  |  |
| --- | --- |
| Exposure to ultrasound [ ]  | How many times and reason:       |
| Invasive procedures [ ]  | Type:       |
| Pets at home [ ]  |  |
| Smokers in the home [ ]  |  |
| Vaccinations [ ]  | Type:       |
| Antibiotics [ ]  | Type:       |

**GROWTH & DEVELOPMENT**

Was the infant alert and responsive with twelve hours of delivery:

* If no, explain:

Any health problems (cancer, diabetes, heart disease, etc.) on either side of the family:

* If yes, explain:

Do sleeping patterns seem normal to you:

* If no, explain:

At what age did the child:

|  |  |  |  |
| --- | --- | --- | --- |
| Respond to sound |       | Follow an object |       |
| Hold up head  |       | Vocalize  |       |
| Walk  |       |  |  |

**TRAUMATIC STRESSORS**

Any trauma during pregnancy:

* If yes, explain:

Any evidence of birth trauma:

|  |  |  |  |
| --- | --- | --- | --- |
| Bruises [ ]  | Odd shaped head [ ]  | Respiratory [ ]  | Depression[ ]  |
| Stuck in birth canal [ ]  | Fast or excessively long birth [ ]  | Cord around neck [ ]  | Other:       |

Any falls from couches, beds, or change tables:

Any traumas with bruising, cuts, stitches, fractures:

Any hospitalizations:

* If yes, explain:

Any surgeries:

* If yes, explain:

Sports played:  Age started:

Number of hours per week spent played:

Approximate hours spent at play per week:

Weight of school backpack:

**PSYCHOSOCIAL STRESSORS**

Any difficulties with lactation:

Any problems bonding:

Any behavioural problems:

Any night terrors, sleep walking, difficulty sleeping:

Age when child began daycare:

Does your child seem “normal” for their age:

* Explain:

Any additional information: