LiveWell
Family Health Centre
Chiropractic • Massage • Fitness Training • Nutrition
Natural Pharmacy • Orthotics • Naturopathy

PEDIATRIC HEALTH HISTORY

Name: _____ Today's Date (D/M/Y): _____

Name you preferred to be called:_____ Date of Birth (D/M/Y): _____ Age___

Address:_____ City:_____ Postal Code:_____

Phone: Home_____ E-mail:_____

Who referred you? /How did you hear about us?: _____

Please list your family physician or most recent physician: _____

Authorization For Care Of A Minor

Mother's name: _____ Father's name: _____
Work Telephone #: _____ Work Telephone #: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.
Parent/ Guardian signature: _____ Date **(D/M/Y):** _____
Witness signature: _____ Date **(D/M/Y):** _____

At LiveWell Family Health Centre, we use e-mail and other forms of electronic communication to conduct regular business with our clients. We never share this information with any individual or third party outside our Centre.
Please initial the following statement:
I give permission to LiveWell Family Health Centre to send me statements, receipts, appointment reminders/calendars, upcoming events notices, newsletters and/or other health information via e-mail.

Please Initial _____

History of Birth

Location of birth: Hospital Home Birthing Centre
Birth attendant: Midwife General Practitioner Obstetrician None
Weeks pregnant at birth:_____ Birth weight: _____ Birth length: _____
Natural Birth: Yes No If no, specify intervention(s) used:
Forceps Vacuum Extraction Forceful Extraction Induced Labor C-section Epidural
List any medications given to mother during birth: _____
List any supplements given to mother during birth: _____
Duration of birth: _____ List any complications at birth: _____
List any medications delivered to child at birth: _____
During pregnancy did the mother: Smoke: Yes No Drink alcohol: Yes No Drink Caffeine: Yes No

Growth and Development

Was the infant alert and responsive after delivery? Yes No, Explain_____
_____
At what age did the child:
Respond to sound _____ Follow an object_____ Hold head _____ Vocalize _____
Sit Alone _____ Teethe _____ Crawl _____ Walk_____
Do sleeping patterns seem normal to you? Yes No, Explain:_____
Began solid foods at age:_____ Type:_____

Chemical Stress

Yes No Was the child breast-fed? How long? _____

Yes No Was formula introduced? At what age? _____ Type of formula used? _____

Yes No Has cow's milk been introduced? At what age? _____ Allergies/reactions _____

Yes No Food / Juice intolerance or allergy? Type: _____

Yes No Any special diets (e.g. vegetarian)? Specify: _____

Yes No Any illnesses of the mother during pregnancy? Specify: _____

Yes No Any medications taken by the mother during pregnancy? Specify: _____

Yes No Any exposures to ultrasound? If so, indicate how many? _____

Yes No Has the child been vaccinated? Any adverse reactions: _____

Chemical Stress (continued)

Yes No Any antibiotics? Reason: _____ Number of courses: _____

Yes No Exposure to cigarette smoke? How much? _____ How long? _____

Yes No Exposure to any other chemicals? Explain? _____

Yes No Does the child take any medications? List: _____

Yes No Does the child eat fast food/prepackaged/frozen meals? How often? _____

Yes No Does the child drink caffeinated beverages? What? _____ How often? _____

Yes No Does the child drink water? How often? _____

Psychosocial/Emotional Stress

Yes No Difficulties with lactation? _____

Yes No Problems with bonding? _____

Yes No Behavioral problems? _____

Yes No Night terrors, sleep walking, bed wetting, difficulty sleeping? _____

Yes No Does the child experience stress in his/her daily life? Rate from 1 (low) to 10 (high)

School	1	2	3	4	5	6	7	8	9	10
Home	1	2	3	4	5	6	7	8	9	10
Peer Pressure	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

Yes No Does the child experience anxiety or nervousness? _____

Yes No Has the child been abused physically, emotionally, or sexually? _____

Yes No Has the child had any other emotional trauma (e.g. posttraumatic stress)? _____

Yes No Does the child watch television? Average number of hours per day? _____

Physical Stress

Yes No Any traumas to the mother during pregnancy (falls/accidents)? _____

Yes No Any evidence of birth traumas? Bruises, odd shaped head, stuck in birth canal, excessively fast or long birth, respiratory depression, cord around neck, in utero constraint, other: _____

Yes No Has the child ever fallen from a significant height? _____

Yes No Has the child ever fallen down stairs or slipped on ice? _____

Yes No Does the child participate in any sports? List: _____

Yes No Did/does the child use walkers, jumpers, swings or similar equipment? _____

Yes No Any other trauma or physical stress? _____

Yes No Does the child have restful sleep? How many hours? _____ Age of mattress? _____

Sleeping posture: Back Stomach Side

Yes No Does the child wear a backpack? Weight of backpack: _____

Hours spent sitting per day (at school, home, etc)? _____

Health History

1) Has your child seen a chiropractor before? Yes No

If yes, Chiropractor's name:_____ Last Visit:_____

X-rays taken: Yes No When: _____

2) What brings you to the office? Wellness_____ Physical Complaint_____

3) Current Complaint (skip for wellness patients)

Chief health concern: _____

When did it start (M/D/Y): _____/_____/_____ Onset was: gradual sudden associated with an event

Has the child had this before: No Yes How many times _____

What do you think is the cause of the problem:_____

What makes it worse: _____

What makes it better: _____

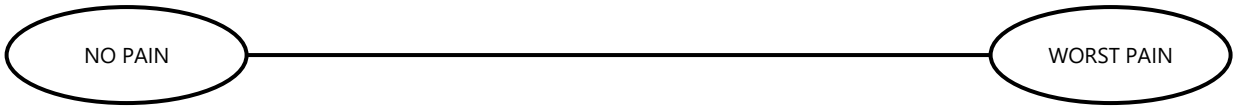
What is the quality of the pain/problem:

❑ Fiery	❑ Radiating	❑ Dull ache	❑ Tingling
❑ Sharp	❑ Weakness	❑ Twitching	❑ Cramping
❑ Swelling	❑ Stiffness	❑ Numbness	❑ Stabbing

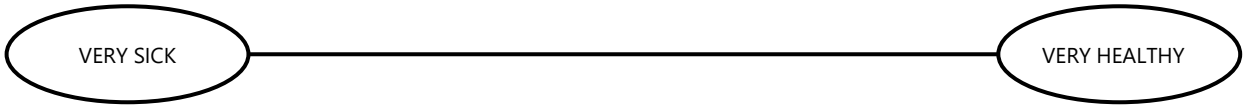
Is this problem: Getting better Getting worse Staying the same

Pattern of the problem: Constant Intermittent Occasional Cyclical, _____times per day/month/year

How would you rate the severity of your child's complaint? Please mark a vertical line on the scale below.



4) How would you rate your child's overall health? Please mark a vertical line on the scale below.



5) Is your child currently taking any medications? Yes No

If yes, please list:_____

6) Is your child currently taking any supplements? Yes No

If yes, please list: _____

7) Please finish the following sentences by circling a number from 1 to 10.

(1 – poor, 5 – average, 10 – excellent)

My child's response to STRESS is:	1	2	3	4	5	6	7	8	9	10
My child's ENERGY LEVEL is:	1	2	3	4	5	6	7	8	9	10
My child's BREATHING is:	1	2	3	4	5	6	7	8	9	10
My child's LEVEL OF RELAXATION is:	1	2	3	4	5	6	7	8	9	10
My child's QUALITY OF SLEEP is:	1	2	3	4	5	6	7	8	9	10
My child's DIGESTION is:	1	2	3	4	5	6	7	8	9	10
My child's MEMORY is:	1	2	3	4	5	6	7	8	9	10
My child's RESISTANCE TO ILLNESS is:	1	2	3	4	5	6	7	8	9	10
My child's FLEXIBILITY is:	1	2	3	4	5	6	7	8	9	10
My child's CONCENTRATION is:	1	2	3	4	5	6	7	8	9	10

8) List any operations, motor vehicle accidents and/or hospitalizations and the year they occurred: _____

_____

_____

9) Please check the conditions your child is experiencing now or has in the past:

General	Ear, Nose & Throat	Cardiovascular	Digestion
❑ Headache	❑ Asthma	❑ High blood pressure	❑ Poor appetite
❑ Fatigue	❑ Bronchitis	❑ Low blood pressure	❑ Constipation
❑ Dizziness	❑ Chronic cough	❑ Heart defect	❑ Diarrhea
❑ Anxiety	❑ Recurrent colds	❑ Slow wound healing	❑ Vomitting
❑ Rash	❑ Short breath	❑ Stroke/ TIA	❑ Crohns/Colitis
	❑ Ear Infections		

Other Conditions			
❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Depression

Use this space to elaborate on any of the above conditions or any conditions that have not been listed:

_____

_____

10) Please list a brief family health history:_____

_____

11) List any activities that your child does to promote good health:_____

_____

_____

12) What health goals would you like to achieve through chiropractic:_____

_____