Child's Personal Health History

Name:______________________________ Referred by:________________________________

Address:____________________________ City:_____________________ Prov:_____________

Postal Code:_________________________ Email:______________________________________

Phone:________________ (c)________________ Date of birth:________________________________

Parents' Names:___________________________ Family doctor's name:__________________________

Your child deserves to be healthy. When we are conceived, we are given the blueprints, intelligence and systems to live an active, healthy, long life. Unfortunately, the natural expression of health can be interfered with. Through your child's examination and involvement in chiropractic care, we will work to remove these interferences and keep them out of their life, so that they can heal and live the quality of life they deserve.

Circle all that apply:

1. Your Child's Birth

Long delivery	Difficult delivery	Forceps/vacuum	Caesarean
Breech	Home birth	Mother given drugs	Induced labor

Comments:____

____

2. Growth and development

Did your child ever….

fall out of bed	bang their head	have an accident	learn to crawl
have a childhood illness	have surgery	take drugs	fall down the stairs
experience other trauma	Breastfeed		

Comments:____

____

3. Current health habits

Does your child….

take medications	eat healthy foods	exercise regularly	
have teeth problems	eye problems	hearing problems	sleeping problems

physical stress/mental stress/ occupational stress

Has your child …. been in accidents had surgery had sports injuries

Sleep posture: side? back? stomach?

Comments:____

____

Current Health Condition

Major Complaint or Crisis? (what is the reason for your visit today?)

____

When did the problem start?____

Is this problem: □constant □intermittent □worsening □occassional

Is this condition interfering with: □school □sleep □routine □other___________

Other practitioners seen for this condition:____

Other Symptoms

□headaches	□face flushed	□Light bothers eyes	□feet cold
□neck pain/stiffness	□low back pain	□loss of memory	□hands cold
□sleeping problems	□pins and needles in legs/arms	□ears ring	□upset stomach
□nervousness	□behavioural problems	□fever	□constipation
□tension	□numbness in toes/fingers	□fainting	□diarrhea
□irritability	□attention problems	□cold sweats	□loss of balance
□chest pains	□shortness of breath	□ear infections	□allergies
□dizziness	□fatigue	□depression	□colic
□frequent colds/flus	□scoliosis	□bed wetting	

□other ____

Family History:	Heart disease	Arthritis	Cancer	Diabetes	Other
Father's side	□	□	□	□	_______
Mother's side	□	□	□	□	_______

Your oldest grandparent on record lived to the age of ______ □Still living □Deceased

As a result of my child's chiropractic care, I would like them to (check all that apply):
□Feel better quickly □Have a healthier spine and nervous system □Live a healthier lifestyle

In order to determine the underlying cause of your child's complaint, Dr. Santin will perform a thorough assessment of your child's spine and nervous system at today's visit. This examination will consist of

I consent to a thorough spinal assessment for my child.

____

Child's name

_______________________________________ ____________________________

Signature of parent Date

neurological and orthopedic tests, as well as an Insight Millennium scan. At your next visit, Dr. Santin will discuss your child's findings, and you will decide on a mutually agreed upon plan of management.