DR. BRIAN DOWER ❖ CHIROPRACTOR

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information on your child. We look forward to working with you and your child(ren) to build better health for your family. (Y = Yes, N = No)

Child's Name:				Date:	
Parent/Guardian Name(s):				Home Phone: ( )	
Street Address:				P/G Work Phone: ( )	
City, Postal Code:					
Child's Health Card Number:				Version:	**OFFICE USE ONLY**
Birth Date: / / day month year	Age:	Gender: M F	School & Grade		
Siblings (Names & Ages)			Emergency contact (name & number):		
Last Chiropractic Visit:		Name of previous Chiropractor:			
Who may we thank for Referring you to our office? Or how did you hear about our office?					

WHAT IS YOUR PURPOSE FOR CONTACTING US? _____

Were other doctors seen for this condition? Yes No

If yes, Doctor(s)' names & prior treatments: _____

Other health problems? _____

Any family history of this condition? Describe _____

Number of antibiotics child has taken: During the Last 6 months: _____ Total during his/her lifetime: _____

Other medications? _____

Vaccination History: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during Pregnancy? Y N List: _____

Complications during Delivery? Y N List: _____

Ultrasound during Pregnancy? Y N Number: _____

Medications during Pregnancy/Delivery? Y N List: _____

Location of Birth: ☐Hospital ☐Birthing Centre ☐Home

Birth Intervention: ☐Forceps ☐Vacuum Extraction ☐Caesarian Section (Emergency / Planned)

Alcohol use during Pregnancy? Y N Tobacco use during Pregnancy? Y N

Apgar Scores? _____ , _____

Birth Weight: _____

Birth Length: _____

Genetic Disorders or Disabilities? Y N List: _____

FEEDING HISTORY

Breastfed? Y N How long? _____

Formula Fed? Y N How long? _____

Introduced: Solids at _____ months Cow's milk at _____ months

Food allergies or intolerances? Y N List: _____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of Vertebral Subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound

_____ Respond to Visual Stimuli

_____ Hold Head Up

_____ Sit Up

_____ Cross Crawl (on hands & knees)

_____ Stand Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children will fall from a high place during their first year of life (ie., off a bed, changing table, down the stairs etc.).

- Was this the case with your child? Y N Describe: _____
  _____
  _
- Is or has your child been involved in any high impact or contact type sports (ie., soccer, football, hockey, gymnastics, baseball, cheerleading, martial arts etc.)? Y N
- Has your child ever been involved in a car accident? Y N Describe: _____
  _____
  _
- Has your child ever been seen on an emergency basis? Y N Describe: _____
  _____
  _
- Any other traumas not described above? Y N Describe: _____
- Prior Surgery? Y N Describe: _____

CHILDHOOD ILLNESSES

Chicken Pox	Y N Age:_____	Mumps	Y N Age:_____
Measles	Y N Age:_____	Whooping Cough	Y N Age:_____
German Measles	Y N Age:_____	Other _____	Y N Age:_____

We are here to serve you, and encourage you to ask any questions you may have. Your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Park Road Healing Arts Centre and its Doctors of Chiropractic to administer chiropractic care and/or acupuncture to my son/daughter as they deem necessary. I clearly understand that I am personally responsible for payment of all fees charged by this office.

Parent Name: _____ Minor's Name: _____

Signed: _____ Date: _____