About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layers of Spinal and Neurological damage (VCS). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care.** All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Loss of Wellness (Birth - Age 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No	(Birth - Age 5)	Patient Comment (if answer is Yes)	Chiropractor's Comments
		1. Pregnancy		
		Did your mother:		
☐	☐	Smoke or drink alcohol?	_____	_____
☐	☐	Have a proper diet?	_____	_____
☐	☐	Exercise through her pregnancy?	_____	_____
☐	☐	Experience any falls and injuries during pregnancy?	_____	_____
☐	☐	Experience any physical and/or mental abuse?	_____	_____
		2. Birth Process		
☐	☐	Was the delivery long?	_____	_____
☐	☐	Was the delivery difficult?	_____	_____
☐	☐	Forceps?	_____	_____
☐	☐	Caesarean?	_____	_____
☐	☐	Breach/cephalic	_____	_____
☐	☐	Home birth?	_____	_____
☐	☐	Hospital Birth?	_____	_____
☐	☐	Mother given drugs during delivery?	_____	_____
☐	☐	Was labour induced?	_____	_____
		3. Growth and Development		
☐	☐	Were you taught how to care for your spine?	_____	_____
☐	☐	Did you roll out of bed?	_____	_____
☐	☐	Were you a head banger or rocker?	_____	_____
☐	☐	Were you breast fed?	_____	_____
☐	☐	Childhood Sickness?	_____	_____
☐	☐	Accidents?	_____	_____
☐	☐	Surgery?	_____	_____
☐	☐	Drugs?	_____	_____
☐	☐	Did you fall while learning to walk?	_____	_____
☐	☐	Were you picked on by siblings?	_____	_____
☐	☐	Child abuse	_____	_____
☐	☐	Spanking (how?)	_____	_____
☐	☐	Pulled ear/chin	_____	_____
☐	☐	Other	_____	_____
☐	☐	Chair pulled out when sat down?	_____	_____
☐	☐	Did you fall down stairs?	_____	_____
☐	☐	Were you yanked by your arm?	_____	_____
☐	☐	Did you have other traumas? What? When?	_____	_____

Pediatric History Form

Dear New Patient:

It is a pleasure to welcome you to our family of happy and healthy
chiropractic patients. Please let us now if there is any ways we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Information

Patient Name_____
Address: _____
City _____Province_____ Postal Code _____
Date of Birth _____ Sex _____ Weight _____ Height _____
Home Phone _____ Work Phone _____
Names of Parents/Guardians: _____

Purpose for Contacting Us? _____
Other Doctors seen for this Condition: ☐ No ☐ Yes
Doctor's Name and Prior Treatments:
_____
Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Other _____
☐ Chronic Colds	☐ Headaches	☐ Asthma/Allergies	
☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	
☐ Growing/Back Pains	☐ Colic	☐ Bed Wetting	
☐ Car Accident	☐ Temper Tantrums	☐ Constipation	

Family History: _____

Previous Chiropractor: _____
Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____
Date of Last Visit: _____ Reason: _____
Are you satisfied with the care your child has received there? ☐ No ☐ Yes

Number of doses of antibiotics your child has taken:
During the past six months: _____ Total during his/her lifetime: _____
Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____
Complications during pregnancy? ☐ No ☐ Yes List: _____
Ultrasounds during pregnancy? ☐ No ☐ Yes Number: _____
Medications during pregnancy? ☐ No ☐ Yes List: _____
Cigarette/Alcohol use during pregnancy: ☐ No ☐ Yes
Location of birth: _____ Hospital: _____
Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ C-Section—Emergency or Planned?
Genetic Disorders or disabilities ☐ No ☐ Yes List: _____
Birth Weight: _____ Birth Length:_____ APGAR Scores: _____, _____

Feeding History:

Breast fed: ☐ No ☐ Yes How long? _____ Formula fed: ☐ No ☐ Yes How long? _____ Type: _____
Introduced to solids at: _____ Months Cow's milk at: _____ Months
Food/Juice Allergies or Intolerances: ☐ No ☐ Yes List: _____
_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or 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
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of the children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc.) Was this the case with your child? ☐ No ☐ Yes

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ No ☐ Yes List: _____
_____
Has your child ever been involved in a car accident? ☐ No ☐ Yes List: _____
Has your child been seen on an emergency basis? ☐ No ☐ Yes List: _____
Other traumas not described above: ☐ No ☐ Yes List: _____
Prior surgery: ☐ No ☐ Yes List: _____
Menarche: ☐ No ☐ Yes Age: _____

Childhood Diseases:

Chicken Pox	☐ No	☐ Yes	Age: _____	Mumps	☐ No	☐ Yes	Age: _____
Rubella	☐ No	☐ Yes	Age: _____	Whooping Cough	☐ No	☐ Yes	Age: _____
Rubeola	☐ No	☐ Yes	Age: _____	Other	☐ No	☐ Yes	Age: _____

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parents/Guardian Signature _____ Date: _____

Witnessed: _____ Date: _____