Vibrant Life Chiropractic

Child's Personal Information

Name_____ Date_____

Address_____ City _____ Province____

Postal Code_____ Date of Birth: D___ M ___ Y _____ Age _____

Home Phone _____Cell Phone _____ E-mail _____

Where do you prefer to be contacted? Home ____ Work ____ Cell ____

Mother: _____ Father: _____

Whom may we thank for referring your child to Vibrant Life Chiropractic?_____

Check the phrase that most represents your child's reason for care:

0 Wellness 0 Prevention 0 Feel good 0 Symptom Relief

Health Concerns

(If there are no current concerns and this assessment is to ensure optimum health and functioning, skip to next page)

Concern	Severity 1=mild 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is the symptom present?

Is this condition interfering with your child's:

0 School 0 Behaviour 0 Sleep 0 Daily Routine 0 Sports/Activities

Other: _____

Is there a family history of similar concerns? 0 Yes 0 No
Please explain _____

What other health practitioners has your child seen? (Mark P for past or C for current)

0 Chiropractor 0 Medical doctor 0 Naturopath 0 Physiotherapist 0 Massage therapist

Other _____

What have you done for this condition? Was it of benefit? _____

Often seemingly unrelated symptoms can tell us information about the function of the nervous system and overall health:

(Please check if your child has had any of the following – past or present)

__ headaches
__dizziness
__fainting
__fatigue
__irritability
__depression
__loss of balance
__loss of concentration
__loss of memory
__poor coordination
__vision changes
__ears buzzing
__loss of smell
__loss of taste
__shortness of breath
__asthma
__urinary problems
__constipation
__diarrhea
__weight loss
__weight gain
__fevers
__heart palpitations
__frequent colds
__sinus congestion
__sore throats
__ear pain/infections
__allergies
__bloating/gas
__upper back pain
__neck pain
__low back pain
__radiating pain
__stiffness
__reduced mobility
__numbness in leg(s)
__numbness in feet
__numbness in hand(s)
__weakness
__muscle cramps
__sleeping problems

Other: _____

PHYSICAL HEALTH:

Please list any childhood falls/accidents
Type:_____ Age: _____ Hospitalized? Y N
Type:_____ Age: _____ Hospitalized? Y N
Type:_____ Age: _____ Hospitalized? Y N

Please list if your child has had any surgeries::
Type:_____ Date: _____ Reason: _____
Type:_____ Date: _____ Reason: _____
Type:_____ Date: _____ Reason: _____

Pregnancy History
Any traumas / illnesses? 0 Yes 0 No _____

Did the mother:
Smoke? 0 Yes 0 No Drink Alcohol? 0 Yes 0 No
Take medication? 0 Yes 0 No

Labour History: Please check all that apply:
0 Drug induction 0 Epidural 0 Antibiotics during labour

Duration of labour: _____ Duration of pushing phase: _____

Was there any assistance used?
0 forceps 0 vacuum / suction 0 manual traction from caregiver 0 c-section

Were there any complications during birth? 0 Yes 0 No
Please explain: _____

Infant health: Please check all that apply:

Was there any evidence of trauma following birth?
0 bruising 0 odd shaped head 0 stuck in birth canal 0 respiratory distress
0 excessively fast birth 0 prolonged labour

Did your child experience any of the following:

0 Incubation How long? _____
0 Separation after birth? How long? _____
0 Colic
0 Digestive problems
0 Nursing difficulties
Other: _____

Was your child breastfed? 0 Yes 0 No For how long? _____

Sports and Activities

Any sports? _____ How often? _____

Does your child carry a backpack? 0 Yes 0 No 0 Heavy 0 Light

Hours per week watching TV? 0-10 10-20 20-30 30-40

Hours per week on the computer? 0-10 10-20 20-30 30-40

BIOCHEMICAL HISTORY

Please list ALL drugs your child currently takes or have taken in the past 6 months:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Please list all nutritional vitamins or homeopathic remedies your child currently takes:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Has your child been vaccinated? 0 Yes 0 No Age of first vaccination: _____

If so, has he/she had a reaction to vaccination? 0 Yes 0 No
If so, please explain: _____

Nutritional Choices

Please grade any dietary selection that is appropriate for your child using the following scale:

FD – consumed a few times per day
FW – consumed a few times per week
FM – consumed a few times per month
M – consumed monthly
D – consumed once per day
W – consumed once a week
O – does not consume this

_____Artificial Sweeteners
_____Caffeine
_____Dairy (milk products)
_____Soft drinks
_____ Breads, pastas
_____Refined Sugar
_____Fried Food

Do you have any dietary concerns for your child? 0 Yes 0 No
If so, please explain:_____
_____

EMOTIONAL/DEVELOPMENTAL HISTORY

Have there been any significant family stresses since your child's birth? 0 Yes 0 No
If so, please explain (include age of child at the time): _____
_____
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Age child began daycare/alternate caregiver: _____ Please circle: Part time / Full time

Have developmental milestones been met? 0 Yes 0 No _____

At what age did your child:

Sit unsupported: _____ Crawl: _____ Stand: _____ Walk: _____
Talk: _____

Do you have any concerns regarding your child's development? 0 Yes 0 No
If so, please explain: _____
_____

Is there anything else you would like to tell us about your child? _____
_____
_____