

## Welcome to **NETWORKchiropractic.ca**

When you have completed this page please hand it into the reception desk.

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# Vital Information (Child)

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Child's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ ext \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email address \_\_\_\_\_

Date of Birth: D \_\_\_ /M \_\_\_ /Y \_\_\_\_\_

Name(s) of Parent(s) \_\_\_\_\_

Other children?  No  Yes - Names (ages): \_\_\_\_\_

Name of additional caretaker(s) \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Has your family seen a chiropractor before?  No  Yes – If so, when? \_\_\_\_\_

Reason for seeking services at **NETWORKchiropractic.ca**: \_\_\_\_\_

How did you find out about **NETWORKchiropractic.ca**? \_\_\_\_\_

Is there anything about your child's nerve system and spine we should know about? \_\_\_\_\_

What is your level of commitment to you and your child's life and well-being?

High

Medium

Low

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

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## Vital Information (Child, Continued...)

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Thank you for completing this more detailed questionnaire. All the information we collect is confidential and is valuable in order for us to provide you with exceptional service. If you have any questions please ask the host or the Chiropractor. Please inform the host or the Chiropractor when you have completed this information.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Name of previous chiropractor and date of last visit? \_\_\_\_\_

Describe Experience \_\_\_\_\_

Name of present MD/Pediatrician and address? \_\_\_\_\_

Date and reason for last MD visit? \_\_\_\_\_

Does your child have any current health concerns? If yes, please describe and complete the following questions, if no move onto \* \_\_\_\_\_

When did this/these health concern(s) begin? \_\_\_\_\_

Have you sought advice or treatment from a health professional?  Yes  No

If yes, what were you told? \_\_\_\_\_

What was done? \_\_\_\_\_ Did it seem to work?  Yes  No

Please indicate how this condition affects your child's daily function and the function of your family? \_\_\_\_\_

What concerns you about this situation? \_\_\_\_\_

Why do you think your child is experiencing this health event? \_\_\_\_\_

\*What are your expectations of your chiropractic care at **NETWORKchiropractic.ca**? \_\_\_\_\_

To develop an understanding about Chiropractic, the body's healing ability, life force and the nervous system we request that you attend one of our special Wellness Lectures during your first month of your child's care. Are you interested in attending one of our seminars?

Yes  No  Will consider

### Family and Personal History:

*Please list whether you or anyone in your close family has a history of any of the following:*

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart disease/high blood pressure \_\_\_\_\_

High cholesterol \_\_\_\_\_

Any other health concerns \_\_\_\_\_

**History of pregnancy, labour and birth:**

*Pregnancy*

Name of Obstetrician/Midwife \_\_\_\_\_

Please list any medical or alternative, treatments or procedures done during pregnancy \_\_\_\_\_

Please list any drugs, herbs or supplements taken during pregnancy \_\_\_\_\_

Please list any traumas to the mother during pregnancy (e.g. accidents, emotional) \_\_\_\_\_

*Labour & Birth*

Birth attendants (MD, Midwife, Doula) \_\_\_\_\_

Location of Birth \_\_\_\_\_

Mother's position during labour (back side, sitting standing, other) \_\_\_\_\_

Was labour induced?  Yes  No

Did the mother receive any drugs before during or after the birth process? (Epidural, Morphine, Other) \_\_\_\_\_

Was an episiotomy performed?  Yes  No

Duration of labour \_\_\_\_\_

Duration of delivery (time spent in birth canal) \_\_\_\_\_

Birth Position?  Cephalic (head first)  Occiput Posterior (facing forward)  
 Breech (feet first)  Other \_\_\_\_\_

Any assistance required during birth? (e.g. forceps, vacuum extraction, manual assistance, Cesarean) \_\_\_\_\_

Any complications during or after birth? (e.g. stuck in birth canal, cord around neck) \_\_\_\_\_

Any evidence of trauma during birth (e.g. bruises, marks) \_\_\_\_\_

Was your child subjected to any procedures following birth?

Silver Nitrate eye drops  Incubation (how long?) \_\_\_\_\_

Vitamin K injection  Separation from mother (how long?) \_\_\_\_\_

Respiration  Other \_\_\_\_\_

Was your child alert and responsive within 12 hours of delivery? Explain \_\_\_\_\_

What was the child's gestational age at birth? \_\_\_\_\_ weeks

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_

Congenital Anomalies or defects present? \_\_\_\_\_

**Growth and Development:**

At what age did your child:

Follow an object \_\_\_\_\_ Respond to Sound \_\_\_\_\_

Hold up head \_\_\_\_\_ Sit unassisted \_\_\_\_\_

Vocalize \_\_\_\_\_ Talk \_\_\_\_\_

Teethe \_\_\_\_\_ Crawl \_\_\_\_\_

Walk \_\_\_\_\_ Run \_\_\_\_\_

**PHYSICAL STRESSORS, activities, habits, traumas or challenges:**

*Please list the details, treatments and age/date (as necessary) of past and present PHYSICAL experiences:*

Surgeries/Hospitalizations \_\_\_\_\_

Falls (e.g. from couches, beds, change table) and accidents \_\_\_\_\_

Traumas resulting in bruises, fractures or stitches \_\_\_\_\_

Car Accidents (describe) \_\_\_\_\_

Other Past or Current Illness/Infection \_\_\_\_\_

How much (and what kind of) exercise does your child get? \_\_\_\_\_

Is a school backpack used?     No             Yes (Heavy)     Yes (Light)

Other \_\_\_\_\_

**CHEMICAL STRESSORS, activities, habits, traumas or challenges:**

*Please indicate present and past exposures during pregnancy to (per day/week):*

Cigarette Smoke \_\_\_\_\_

Alcohol/Caffeine \_\_\_\_\_

Supplements: \_\_\_\_\_

Medications/procedures (e.g. amniocentesis, ultrasound) \_\_\_\_\_

Was your child breastfed?     No             Yes (until what age?) \_\_\_\_\_

Introduced to formula?     No             Yes (at what age?) \_\_\_\_\_

Introduced to cows milk?     No             Yes (at what age?) \_\_\_\_\_

Solid foods at what age? \_\_\_\_\_

Please list your child's history of antibiotic use and types \_\_\_\_\_

Please list your child's history of vaccinations and the age given \_\_\_\_\_

Reason for vaccinations? \_\_\_\_\_

Any adverse reactions? \_\_\_\_\_

Any smokers in the home? \_\_\_\_\_

Any pets in the home? \_\_\_\_\_

*What are your child's typical daily food choices:*

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

What is your child's daily fluid intake? How many glasses of:

Water \_\_\_\_\_ Juice \_\_\_\_\_ Pop \_\_\_\_\_ Dairy \_\_\_\_\_

Other \_\_\_\_\_

**EMOTIONAL/MENTAL STRESSORS activities, habits, traumas or challenges:**

Any problems with lactation and/or feeding? \_\_\_\_\_

Any problems with bonding with your child? \_\_\_\_\_

Any behavioural problems? \_\_\_\_\_

Any emotional traumas? (e.g. death in family, abuse, school) \_\_\_\_\_

Does your child sleep through the night?  Yes  No Sleeping Position? \_\_\_\_\_

How many hours does your child sleep a night? \_\_\_\_\_ Quality? \_\_\_\_\_

Any night terrors, sleep walking, bedwetting or difficulty sleeping? \_\_\_\_\_

How many hours per week does your child watch television? \_\_\_\_\_

Approximate hours of playtime per week \_\_\_\_\_

Do you feel that your child's physical, social and emotional development is normal for their age?  
(Please explain) \_\_\_\_\_