Paediatric History Form (Age 0-12 years)

Patient name: _____ Date:_____

Parents/ Guardians: _____

Address:_____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email address: _____

Do you consent to having our monthly newsletter sent to you? Yes___ No___

Date of Birth: _____ Weight: _____ Height: _____

Who may we thank for referring you to our office? _____

Health History: Many Childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine.

What is your purpose for contacting us? _____

Other Doctors seen for this condition and course of treatment: _____

_____

Many childhood illnesses can be due to misaligned vertebrae and pinched nerves in the spine. Has your child suffered from any of the following in the past six months?

__Ear Infections	__Scoliosis	__Learning Difficulties	__Sleeping Difficulties	__Other _____
__Tonsillitis	__Digestive problems	__Chronic Colds	__Headaches	
__Asthma/ Allergies	__Bed Wetting	__Recurring fevers	__Growing Pains	
__Colic	__Seizures	__Temper Tantrums	__Back Problems	
__Dizzy/Clumsy	__ADHD	__Scoliosis	_ plagiocephaly	

Previous Health provider:

_____

Date of last visit: _____ Reason: _____

Paediatrician: _____

Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken in past 6 months: _____ in lifetime: _____

Number of doses of prescription medications your child has taken in past 6 mnths ___ Lifetime: _____

List: _____

Vaccination History: _____

Family History of Disease/Illness: _____

Prenatal History: Often, birth trauma can produce some of the first spinal problems in the delicate spine of a newborn.

Name of Midwife or Obstetrician: _____

Did you have any complications during your pregnancy: Y/N Explain: _____

Did you have ultrasounds during pregnancy: Y/N Number: _____

Did you smoke or consume alcohol during your pregnancy: Y/N

Were any of the following interventions used in your delivery (circle)?

Forceps Vacuum Extraction Induced Epidural C-section Other: _____

Were there any complications during your delivery? Y/N Explain (collarbone broken / hematoma etc)

_____

Birth Weight: _____ Birth Length: _____ APGAR at birth: _____ at 5minutes_____

Feeding History:

Was your child breastfed? Y/N For how long? _____

Was your child formula fed? Y/N For how long?_____ Type: _____

When did you first introduce solids? _____ mnths. When did you introduce cow's milk? _____ mnths.

Does your child have any food or juice allergies/intolerances? _____

Developmental History: Many childhood falls can produce long-term spinal misalignments that may surface many years later in life.

How old was your child when he /she first walked? _____

How old was your child when he/she first crawled? _____

Does your child suck his or her thumb? _____

Does your child use a pacifier? _____

In what position does your baby sleep? _____

Does your baby turn his or her head more to one side than the other? _____

How is your baby's breathing ? (noisy / quiet) _____

Has your child ever fallen from a change table, tree, bicycle, crib, stair or other height?
Explain:_____

Has your child ever been in a car accident? Y/N Explain: _____

Has your child ever had a sports injury or been involved in a high impact or contact sport (soccer, football, hockey, gymnastics, cheerleading, martial arts)? Y/N Explain: _____

_____

Has your child ever had surgery or been seen on an emergency basis? _____

Menarche: Y/N Age: _____

We are here to serve you and encourage you to ask questions. Your participation in your family's care is vital and will help determine your child's results.

Authorization for care of a minor:

I, _____(please print name of parent/guardian), hereby authorize Sonya Romanowski B.Sc. Kin, RMT, DOMP, DSc O 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.

Signed: _____ Witnessed: _____ Date: _____