Child History Form

Touch of Life
46755 Hayes Road
Shelby Township, MI 48315
586-532-5433

Child's Full Name____________________________________ Today's Date__________

Date of Birth___________ Age_________ S.S.#__________________________________

Address____

Zip___________ Home # (   )________________ Referred by_____________________

Parent/Guardian Name(s)____

Insurance Company____

Policy #____________________________________ Group # ____________________

Card Holder Name _______________________Card Holders Date of Birth____________

Sibling's Names (ages)____

Has your child ever received Chiropractic care? ***YES*** ***NO***

If yes, previous DC's name and last visit date____

Name of Medical Doctor____

Date of last MD visit and reason____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

Parent's Name__________________________ Work # (   )_________________

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature____________________________ Date________

Witness Signature_________________________________ Date_________

Present Health Complaints/Concerns:

Major____

Minor____

When did the problem begin?____

Is this problem (circle) ***occasional*** ***frequent*** ***constant*** ***intermittent***

Does the problem radiate? ***YES*** ***NO*** If yes, where?__________________________

What makes it worse?____

What makes it better?____

Is the problem worse during a certain time of the day? ***YES*** ***NO***

If YES, then when?____

Does this interfere with the child's (circle) ***sleep*** ***eating*** ***daily*** ***routine***

Is this becoming worse?

Other professionals seen for this condition?_________________________________

Results with treatment?____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS:

(Please check if your child has had, or has any of the following)

____chest pressure	___shortness of breath	___dizziness	___loss of smell
____breast pain	___asthma	___fainting	___loss of taste
____frequent colds	___urinary problems	___fatigue	___light sensitivity
____sinus congestion	___constipation	___irritability	___ face flushed
____sore throats	___diarrhea	___depression	___cold sweats
____ear infections	___weight loss	___loss of balance	___bronchitis
____allergies	___weight gain	___loss of concentration	___pneumonia
____heart burn	___dental problems	___loss of memory	___difficulty breathing
____bloating/gas	___fevers	___ears buzzing	___radiating pain
____upper back pain	___heart palpitations	___stiffness	___numbness in legs
____neck pain	___low back pain	___reduced mobility	
____weakness	___numbness in hands	___poor coordination	
____muscle cramps	___headaches	___vision changes	

MEDICATION

Present prescription drugs	Past prescription drugs	Over the counter drugs
____________________	____________________	____________________
____________________	____________________	____________________

HISTORY OF BIRTH

What was the child's gestational age at birth?________________weeks.
Birth weight______lbs_____oz   Birth length_____________inches.

Was your child born (circle)   ***at home***   ***in a birthing center***   ***in a hospital***
Was the birth considered (circle)   ***medical***   ***midwife***
What was the duration of the labor and birth?_________hours.
Was the child born (circle)   ***cephalic (head first)***   ***breech (feet first)***
Were there any complications?   ***YES***   ***NO***
If YES, please explain____

Please circle any assistance which was used at birth

Forceps   ***Vacuum extraction***   ***C-section***   ***Episiotomy***

Was labor (circle)   ***spontaneous***   ***induced***
Were medications or epidurals given to the mother during birth?   ***YES***   ***NO***
If YES, what was given____
APGAR score: at Birth_____/10   After 5 minutes_______/10

FAMILY HEALTH HISTORY

Please note any health problems (i.e. Cancer, hereditary conditions, diabetes, heart disease etc.)

Mother's family____
Father's family____
Siblings____

Since problems that Chiropractors look for and can detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (I.e. Falls, accidents, etc.)   ***YES***   ***NO***
If YES, please explain____
Any evidence of birth trauma to the infant? (please check)
___bruising   ___odd shaped head   ___stuck in birth canal
___fast or excessively long birth ___respiratory depression ___cord around neck
Any falls from couches, beds, change tables, etc.?   ***YES***   ***NO***
If YES, please explain____

Any traumas resulting in bruises, cuts, stitches, or fractures?   ***YES***   ***NO***
If YES, please explain____
Any hospitalizations or surgeries?   ***YES***   ***NO***
If YES, please explain____
Any sports played? ____
Is a school backpack used?   ***YES***   ***NO***
Is it   ***HEAVY*** or ***LIGHT*** (circle)

CHEMICAL STRESSORS

Was this child breast-fed? ***YES*** ***NO*** If YES, how long?______________________
Formula introduced at what age?_______________________ What formula____________
Introduction of cow's milk at what age?________Began solid foods at what age?_______
Food/Juice intolerance? ***YES*** ***NO*** Type?___________________________

During pregnancy did the mother smoke? ***YES*** ***NO*** How much?____________
drink? ***YES*** ***NO*** How much?____________
Any illnesses during pregnancy? ***YES*** ***NO***
Any supplements taken during pregnancy? ***YES*** ***NO***
Any drugs taken during pregnancy? ***YES*** ***NO***
Any ultrasounds? ***YES*** ***NO*** How many?___________
Any invasive procedures during pregnancy (i.e. amniocentesis etc.) ***YES*** ***NO***

If YES, please explain____

Any pets at home? ***YES*** ***NO***
Any smokers at home? ***YES*** ***NO***

Vaccination History

Vaccinations and age given____

____

Any negative reactions? ***YES*** ***NO***
If YES, please explain____

Any antibiotics given? ***YES*** ***NO***
If YES, please give name____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ***YES*** ***NO***
Any problems with bonding? ***YES*** ***NO***
Any behavioral problems? ***YES*** ***NO***
Any night terrors, sleep walking, difficulty sleeping? ***YES*** ***NO***
Age of child when he/she began daycare?_____________________
Average number of hours of television per week?______________
Do you feel your child's social and emotional development is normal for their age? ***YES*** ***NO***

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

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