Kingston West Family Chiropractic
dedicated to excellence in natural family health
Dr. Adrina Patterson D.C.

743 Cataraqui Woods Drive, Unit 1
Kingston, ON K7P 2R1
Phone: (613) 389-5331 Fax: (613) 389-7246
E-mail: info@kwfc.ca
www.kwfc.ca

Child History Form

Child's Name: _____ Date (M/D/Y):_____

Mother's Name: _____ Father's Name: _____

Address : _____ City, Province _____ Postal Code _____

Home Phone: _____ Mother's Work Phone: _____ Father's Work Phone_____

Birth Date: (M/D/Y)_____ Age: _____ Current Weight: _____

Referred by: _____

Obstetrician/Midwife: _____
Name Located at

Pediatrician/Family MD _____
Name Located at

Date of Last Visit to MD:_____ Purpose:_____

Previous Chiropractor:_____
Name Located at

Date of Last Visit to D.C. _____Purpose: _____

Insurance Company: _____ Policy Number: _____

Policy Holder: _____

Authorization for Care of a Minor

Parent/Guardian Names _____
I hereby authorize and consent to the chiropractic care and evaluation of my child.
Signed _____ Witnessed _____ Date _____

I realize that I am responsible for all fees charged by the clinic and that I will pay for all services as they are performed.
Signature: _____ Date: _____

Chief Health Concerns:

Reason for contacting us:_____

List other care undergone for this complaint (including medication):_____

_____

Date of Onset: _____ Onset was: Sudden θ Gradual θ Associated with an Eventθ
Duration of Problem (episode) _____ minutes / hours / days / months / years
Pattern of problem: Constant θ, Intermittent θ, Occasional θ , Cyclical θ
Initiating Factors: _____
What makes it worse? _____
What makes it better?_____
Effects of problems on body function and daily activities _____

_____
Prior occurrence or episodes: _____

History of Birth:

Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Home: _____ Birthing Centre: _____ Hospital:_____

Duration of Gestation: _____ Duration of Birth _____

Medications delivered to mother at birth: No __ Yes: If yes what? _____

Problems During
Pregnancy: _____

Problems During
Labour/Delivery:_____

Apgar Scores at birth: _____ Apgar Scores at 5 minutes_____

Birth Weight: _____ Birth Length: _____

Growth and Development

Was the infant alert and responsive within twelve hours of delivery? Yes ___ No ___
(Explain)_____
At what age did the child? Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____ Sit alone _____
Teethe _____ Crawl _____ Walk _____
Do sleeping patterns seem normal to you: Yes ___ No___ Explain _____
Any health problems (cancer, diabetes, heart disease, etc.)
On mother's side of the family _____
On father's side of the family _____
With Siblings _____

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

Chemical Stressors

Was the baby breast –fed? No ___ Yes ____ For how long? _____

Formula introduced at age _____ Type of formula used _____

Introduction of Cow's milk at age _____ Began solid foods at age _____ Type _____

Age & type of commercial baby food introduction _____

Food/Juice intolerance No ___ Yes ___ Type: _____

During pregnancy did the mother smoke? Yes _____ No _____

Did the mother drink alcohol? Yes ____ No ____

Any illness of the mother during pregnancy _____

Any supplements taken by mother during pregnancy? _____

Any drugs taken during pregnancy? _____

Any exposure to ultrasound: No ____ Yes ____ If so, how many and what was the medical reason _____

Any invasive procedures (amniocentesis, CVS) _____

Any pets at home: No ____ Yes _____

Any smokers in the home: No ____ Yes ____ (How much?) _____

Any Vaccinations: Which ones and any reactions? _____

Any antibiotics: No ___ Yes ____ Explain: _____

Total number of courses of antibiotics to date: _____

Psychosocial Stressors

Any difficulties with lactation: No ___ Yes _____

Any problems with bonding: No ____ Yes_____

Any behavioural problems: No _____ Yes _____

Any night terrors, sleep walking, difficulty sleeping No____ Yes _____ Specify _____

Age of child when he/she began daycare _____

Average number of hours of television per week _____

Does your child seem normal for their age? Yes _____ No _____ Explain _____

_____

Traumatic Stressors

Any traumas during pregnancy (falls, accidents) _____

An evidence of birth trauma: bruises ____, odd shaped head____, stuck in birth canal____, fast or excessively long birth____, respiratory depression_____, cord around neck_____, other _____

Any falls from couches, beds, change tables _____

Any traumas with bruising, cuts, stitches, fractures _____

_____

Any hospitalizations: No ____ Yes ____ Explain _____

Any surgeries or organs removed _____

Sports played and age began participation _____

Number of hours per week played _____

Weight of school back pack _____

Approx. hours spent at play per week _____

Thank you for completing this form. Please write any other questions or health concerns you have below.