Keenan Health Centre | 303 Harmer Ave S., Ottawa ON K1Y 3B3 | 613-728-9414 | www.ottawahealth.ca
□ Dr. Dirk Keenan DC | □ Dr. Richar Raigoza DC | □ Dr. Chris Martin DC

Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: ______________________________ Date: ______________
Parent(s) Name: ______________________________
Sibling(s) Name(s) (Ages): ______________________________
Address: ______________________________ City: ______________ Prov. __________
Postal Code: __________ Home Phone: (____) ______________ Bus Phone: (____) ______________
Date of Birth: ______________ Age: ____ Gender: ☐ M ☐ F ☐ O Referred by: ______________

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(S): ______________________________ WORK TEL: ______________
I hereby authorize and consent to the chiropractic evaluation and care of my child.
PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ________
WITNESS SIGNATURE: ______________________________

Present Health Complaints/Concerns:

Major: ______________________________
____
Minor: ______________________________
____
When did this problem begin? ______________________________
Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent
Does problem radiate? ☐ Yes ☐ No If yes, where? ______________________________
What makes this worse? ______________________________
What makes this better? ______________________________
Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? ______________
Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?
Is this becoming worse? ______________________________
Other professionals seen for this condition? ______________________________
Results with that treatment? ______________________________
____

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OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness in Leg(s)
☐ Loss of Concentration	☐ Shortness Of Breath	☐ Sinus Congestion	☐ Numbness in Feet
☐ Loss of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness in Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: ____

History of Birth

What was the child's gestational age at birth? ________ Weeks.

Birth weight ______lbs.______ oz. _________ Birth length ______inches

Was your child's birth ☐at home ☐in a birthing center ☐in a hospital

Was the birth considered ☐ medical ☐midwife

What was the duration of the labour and birth?______ hours

Was child born ☐ Cephalic (head first) ☐Breech (feet first)

Were there any complications? ☐ Yes ☐No If yes, please explain ______________________

____

Please check any assistance which was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

Was labour ☐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

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _______

____

At what age did the child: Respond to sound _____Follow an object ____ Hold up head ______Vocalize______
Sit alone_____________Teeth_____________ Crawl ____________Walk ________

Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No If no, please explain_________________

____

Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family ____________________

Father's family ____________________

Sibling(s) ____________________

Since problems that chiropractors look for and 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? (Eg. Falls, accidents, etc.) ☐ Yes ☐ No If yes, please explain ____________________

Any evidence of birth trauma to the infant?

☐ 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 If yes, is it ☐ Heavy ☐ Light

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? __________ Type of foods? __________

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type? ____________________

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? __________

drink? ☐ Yes ☐ No How much? __________

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? ____________________

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? ____________________

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? ____________________

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Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? ______________________________

____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain ___

____

Any pets at home? ☐Yes ☐No If yes, what kind(s)? ____

Any smokers in the home? ☐Yes ☐No

Vaccination History

Vaccinations and age given?____

Any negative reactions? ☐Yes ☐No If yes, what were they? ________________________________

Any antibiotics given? ☐Yes ☐No Reason?____

Psychosocial Stressors

Any difficulties with lactation? ☐Yes ☐No If yes, what are they? ____________________________

Any problems with bonding? ☐Yes ☐No If yes, what are they? ____________________________

Any behavioural problems? ☐Yes ☐No If yes, what are they? ____________________________

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? ____________

Average number of hours of television per week? ____________

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No If yes, how? ____

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.