

Windmill Family Wellness Center Child History Form

Please answer the questions on this form as completely as possible. If you need assistance, please ask Anne or Jennifer and they will be happy to assist you.

Child's Name _____ Today's Date _____
Parent Name(s) _____
Siblings Name(s) and Age(s) _____
Street Address _____
City _____ State _____ Zip Code _____
Home phone _____ Alternate phone _____
Date of Birth _____ Age _____
Who invited you to our office? _____

Has your child ever received chiropractic care? **Yes** **No**
If yes, previous provider's name and date of last visit _____
Name of medical doctor _____
Date and reason for last MD visit _____

Authorization for Care of a Minor Child Under 18 Years of Age

Parent(s) _____ Contact Tel. _____

**I hereby authorize and consent to the chiropractic
evaluation of my child, _____**

Parent / Guardian Signature _____ Date _____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem (circle one) *Occasional* *Frequent* *Constant* *Intermittent*

Does this problem radiate? **Yes** **No**

If yes, where/how? _____

Is the problem worse during a certain time of the day? **Yes** **No**

If yes, when/how? _____

What makes this worse? _____

What makes this better? _____

Does the problem interfere with the child's sleep? _____ Eating? _____ Play? _____

Is the child's daily routine affected? _____

Is this becoming worse? _____

Other professionals seen for this condition _____

Results with any treatment(s) _____

OFTEN, SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS

Please circle 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 flushing | 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 foot/feet |
| Loss of memory | asthma | sore throat | numbness in hand(s) |
| Ears buzzing/ringing | 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 | vomiting |

Other(s): _____

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 (circle one) *at home* *in a birthing center* *in a hospital*

Was the birth considered *Medical* *or* *Midwife*

What was the duration of labor and birth _____ minutes/hours

Was the child born *Cephalic (head first)* *Breech (feet first)*

Were there any complications to the delivery? If yes, please explain

Please circle any form of assistance that was used during delivery:

Forceps

Vaccum extraction

Ceserean

Episiotomy

Was labor *spontaneous* *induced*

Were medications or epidurals given to the mother during birth? If yes, what was given?

APGAR Scoring:

at birth _____ / 10

after 5 minutes _____ / 10

GROWTH AND DEVELOPMENT

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

At what age did the child:

| | |
|------------------------|------------------------|
| Respond to Sound _____ | Follow an Object _____ |
| Hold up Head _____ | Vocalize _____ |
| Sit alone _____ | Teethe _____ |
| Crawl _____ | Walk _____ |

Do you consider the child's sleeping pattern normal? If no, please explain

FAMILY HEALTH HISTORY

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

Mother's Family _____

Father's Family _____

Siblings _____

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? (i.e. falls, accidents, etc.)

Please explain _____

Any evidence of birth trauma to the infant, such as:

| | |
|------------------------|--------------------------------|
| Bruising | Odd shaped Head |
| Stuck in Birth Canal | Fast or excessively long birth |
| Respiratory depression | Cord around neck |

Any falls from couches, beds, changing tables, etc? Please explain _____

Any traumas resulting in bruising, cuts, stitches or fractures? Please explain _____

Any hospitalizations or surgeries? Please explain _____

Is a school backpack used? _____

CHEMICAL STRESSORS

Was the child breast-fed? **Yes No**

If yes, for how long? _____

Formula introduced at what age? _____ Which formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Any food or 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** _____

Any supplements taken during the pregnancy, or while nursing? **Yes No** _____

Any medications and/or drugs used during the pregnancy? **Yes No** _____

Any ultrasounds performed? **Yes No**

How many and reason(s) for being done? _____

Any invasive procedures during pregnancy (i.e. amniocentesis, CVS)? **Yes No**

Please explain _____

Any pets at home? **Yes No** _____

Any smokers in the home? **Yes No**

Vaccination History:

Has your child been vaccinated? **Yes No**

What age(s) were vaccinations given? _____

Any negative reactions? If yes, please explain _____

Any antibiotics given? If yes, at what age(s) and for what reason(s)? _____

PSYCHOSOCIAL STRESSORS

Any difficulties with nursing? **Yes No** _____

Any difficulty or interference with bonding? **Yes No** _____

Any behavioral problems? **Yes No** _____

Any problems with night terrors, sleep walking or other difficulties sleeping? **Yes No**

Does child attend daycare/school? **Yes No**

Average number of hours of television per week? _____ minutes/hours

Do you feel that your child's social and emotional development is normal for his/her age? **Yes No**

Thank you for completing this form. We are committed to improving the quality of your child's Health and Life in every way we can, if there are any other concerns you have regarding your child, or any other information you would like to share with us, please do so in the space provided below.
