Child History Form

File #:	Date:		
Last Name:		Birth date:	
First Name:	Middle:	Age:	Sex:
Email:			
Preferred Method of Contact(1): ☐ Email ☐ Phone		Which of our patients referred you?:	
Address:	City:	Province:	
Postal Code:	Cell Phone:	Home Phone:	
Mother:	Father:	Siblings:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	Province:	Postal Code:
Date of last Visit: / /	Date of last exam: / /		
Have you ever been to a Chiropractor before?: ☐ No ☐ Yes, Were x-rays taken: ☐ No ☐ Yes		When:	

Mostly For Moms: Tell us about your pregnancy:

☐ Midwife	☐ C-Section	☐ Induced	What was the baby's **APGAR** score:
☐ Hospital	☐ Forceps	☐ Epidural	**APGAR** score after 5minute:
☐ Obstetrician	☐ Vacuum Extraction	☐ Difficult Birth	
Did you breast feed?	How long?	What formula did you use?	
Did you consume alcohol?		How much?	
Did you smoke?	How much?	How long?	
What medications did you take?			
How many ultrasounds were you exposed to?			

As a Baby/toddler (0-4 y.o.) did any of the following occur?

☐ Fall from change table	☐ Play in Jolly jumper	☐ Frequent fevers	☐ Colic
☐ Tumble down stairs	☐ Frequent ear infections	☐ Frequent bouts of diarrhea	☐ Did not gain weight
☐ Fall out of crib	☐ Tonsillitis	☐ Constipation	☐ Rheumatic fever
☐ Involved in a car accident	☐ Reaction to a vaccine	☐ Sleeping problems	☐ Prescribed Antibiotics
☐ Fall off playground equipment	☐ Frequent crying spells	☐ Frequent Colds	
Other:			

As a young child (5-12 y.o.) did any of the following occur?

☐ Fall from tree	☐ Sports Accident	☐ Bed wetting	☐ Asthma
☐ Fall off playground equipment	☐ Stomach pains	☐ Hyper Activity/Autism	☐ Allergies
☐ Fall from a bicycle	☐ Scoliosis	☐ Learning Difficulties	☐ Knee/leg pains
☐ Involved in a car accident	☐ Concussion	Other:	

As a child or adolescent, has your child experienced any of the follow?

☐ Headaches	☐ Numbness in arms/hands	☐ Severe Weight gain/loss	☐ Shoulder Pains
☐ Dizziness	☐ Arm/wrist pains	☐ Foot/ankle/knee pains	☐ Growing Pains
☐ Ringing in ears	☐ Stomach Problems	☐ Tingling in arms/legs	☐ Concussion
☐ Fatigue	☐ Sleeping Problems	☐ Neck/back pains	☐ Prescribed Antibiotics
Other:			
Current medications:			

Guardian's Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your record at our office.

Dr. Sheldon Campbell, BSc., D.C. & Dr. Matthew McKeagan, B.Kin., D.C.
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