Pediatric History Form

Dr.Joan Shaben
Chiropractor
Lendrum Health Centre

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Personal Information

Patient Name:_____ Alberta Health Care #_____
Birth Date:_____ M F Weight _____lbs Height_____
Address:_____ City_____ Province_____
Postal Code:_____ Referred by _____
Name of Parent / Guardian _____
Reason(s) for visit:_____
Other doctors seen for this Condition: yes no Doctor(s) name:_____
Prior treatments:_____
Other health problems:_____
Please check any of the following your child has suffered from during the past six months:

__Ear Infections	__Scoliosis	__Seizures	__Chronic Colds
__Headaches	__Asthma/Allergies	__Digestive Problems	__ADHD
__Recurring Fevers	__Colic	__Bed Wetting	__Car Accident
__Growing/Back Pain	__Temper Tantrums	__Other_____	

Family Health History:_____

Previous Chiropractors?_____ Date of last visit:_____
Reason:_____
Name of Pediatrician:_____ Date of last visit:_____
Reason:_____
Prescriptions your child has taken:
Past six months:_____
During lifetime:_____
Vaccination History:_____

Prenatal History

Name of Obstetrician / Midwife:_____
Complications during pregnancy? yes no List:_____
Ultrasounds during pregnancy? yes no Number:_____
Medications during pregnancy / delivery? yes no List:_____
Cigarette / Alcohol abuse during pregnancy? yes no
Location of birth: ____ hospital _____home _____birthing centre
Birth Intervention: ____ forceps ____vacume extraction ____caesarian section, emergency or planned?
Complications during delivery? yes no List:_____
Genetic disorders or disabilities? _____

Feeding History:

Breast fed: yes no How long?_____ Formula fed: yes no How long?_____
Introduced to solids at:_____months Milk at _____months Type of milk_____
Food / Juice Allergies or Intolerances: _____

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Developmental History

During the following times your childs spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to sound
_____Respond to visual stimuli
_____Hold up head
_____Sit Up
_____Cross Crawl
_____Stand Alone
_____Walk Alone

Has your child had any major falls? yes no From heights? (ex. off a bed, change table, down stairs?)_____ Did they land on their head? yes no

Is or has your child been involved in any high impact or contact sports? (ex. soccer, football, gymnastics, martial arts, etc.) yes no Please List:_____

Has your child ever been in a car accident? yes no Details:_____
Has your child ever been seen on an emergency basis? yes no Details:_____
Other Traumas not listed above? _____
Prior Surgery? yes no Details: _____

Childhood Diseases:

___Chicken Pox Y/N Age:_____
___Rubella Y/N Age:_____
___Rubeola Y/N Age:_____
Mumps Y/N Age:_____
Whopping Cough Y/N Age:_____
Other_____

Authorization for Care of Minor

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature of Parent or Gaurdian:_____Date:_____
Name of Insurance Company:_____Contact info._____
_____