Fergus Family Chiropractic Wellness Centre
370 St. Andrew St. W., Unit 1 Fergus, ON N1M 1N9 519-843-1500

CONFIDENTIAL PEDIATRIC HISTORY FORM

Name:			Date:
Name of Parents/Guardians:		Referring Health Professional:	
Address:		City:	Postal Code:
Home Phone: ( )	Parent's Work Phone: ( )	Parent's Email	
Weight:	Height:	Date of Birth D M Y	Age: Sex: □ Male □ Female
Extended Health Insurance? □ Yes □ No Details (Provider, Employer, Policy Nos.):			

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis, we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: Not even felt until they become serious. Please answer every question.

General Health Care:

Reason for seeking chiropractic care: □ Spinal Check-up □ Other (explain):

Other Doctors seen for this condition: □ Yes □ No Doctor's name:

Prior treatment:

Other Health Problems:

Pertinent Family Health History:

Previous Chiropractor: Date of Last Visit: D M Y

Reason:

Primary Health Practitioner: Date of Last Visit: D M Y

Reason:

Are you satisfied with the care your child received there? □ Yes □ No

Number of doses of antibiotics your child has taken: _____

During the last 6 months: _____ Total during his/her lifetime: _____

Number of doses of other prescription medications your child has taken: _____

During the last 6 months: _____ Total during his/her lifetime: _____

Have you chosen to vaccinate your child? □ Yes □ No Reactions following vaccination (up to 30 days post vaccine):

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy: □ Yes □ No Details: _____

Ultrasounds During Pregnancy: □ Yes □ No Number: _____

Complications During Delivery: □ Yes □ No Details: _____

Prenatal History (Continued):

Medications During Pregnancy/Delivery: □ Yes □ No List: _____

Location of Birth: □ Hospital □ Birthing Centre □ Home

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarean Section: □ Planned □ Emergency

APGAR Scores: _____ Cigarette Use During Pregnancy: □ Yes □ No Alcohol: □ Yes □ No

Genetic Disorders or Disabilities: □ Yes □ No Details: _____

Birth weight: _____ Birth length: _____

Feeding History:

Breast Fed: □ Yes □ No How long: _____ Formula Fed: □ Yes □ No How long: _____

Type: _____

Introduced to Solids at: _____ months Introduced to Cow's Milk at _____ months

Food/Juice Allergies or Intolerances: □ Yes □ No List: _____

Developmental History:

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (ie: a bed, changing table, down stairs, etc.). Was this the case with your child? □ Yes □ No

Is/has your child been involved in any high impact or contact type sports (ie: soccer, football, gymnastics, cheerleading, martial arts, etc.)? □ Yes □ No Details: _____

Has your child been involved in a car accident? □ Yes □ No Details: _____

Has your child ever been seen on an emergency basis? □ Yes □ No Reason and Date: _____

Other traumas not described above: □ Yes □ No Details: _____

Hospitalizations or prior surgery: □ Yes □ No Details: _____

Childhood Diseases:

Chicken Pox	□ Yes □ No Age: _____	Mumps	□ Yes □ No Age: _____
Rubella	□ Yes □ No Age: _____	Whooping Cough	□ Yes □ No Age: _____
Rubeola	□ Yes □ No Age: _____	Other: _____	□ Yes □ No Age: _____

Does your child or his/her siblings suffer from:

	Child	Sibling		Child	Sibling
Asthma	□ Yes □ No Age: _____	□ Yes	Skin Problems	□ Yes □ No Age: _____	□ Yes
Allergies	□ Yes □ No Age: _____	□ Yes	Difficulty Sleeping	□ Yes □ No Age: _____	□ Yes
Hyperactivity	□ Yes □ No Age: _____	□ Yes	Colic	□ Yes □ No Age: _____	□ Yes
Bed Wetting	□ Yes □ No Age: _____	□ Yes	Digestive Difficulties	□ Yes □ No Age: _____	□ Yes
Ear Infections	□ Yes □ No Age: _____	□ Yes	Constipation, diarrhea	□ Yes □ No Age: _____	□ Yes

Authorization for Care of Minor

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. By signing here, I verify that the above information is true and accurate regarding my health history. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I have read the above statements and consent to treatment.

Signature: _____ Date signed: _____