SHIOZAWA
WELLNESS CENTER

Child History Form

Date:

Please complete this detailed history form as best as possible. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: Home telephone:
Address: Postal Code:

GP's Name: Date of Birth:
Name of Previous Doctor of Chiropractic:
Date of Last Visit:

Child's Height: Child's Weight:

Name(s) of Parent(s) or Guardian(s):
Business Telephone:

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: Witness:

What are your chief concerns, if any, with your child's health?

Are you here for a Wellness and Spinal Check-up? Yes No

What is your main reason for contacting us?

Date it started:

List any other care your child has undergone with regards to this complaint including medication:

Onset was: (circle one) Sudden Gradual Associated with an event

Duration of problem or episode: (circle one) Minutes Hours Days Months Years

Pattern of Problem: (circle one) Constant Intermittent Occasional

Initiating Factors: Aggravating Factors:

Relieving Factors:

How does the problem affect your child's body function and daily activities?

Prior Occurrence or episodes?

Other Health Concerns?

History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ weeks

Was the baby breech at any time during the pregnancy? □ Yes □ No Did you attempt an ECV □ Yes □ No

Did you have an epidural? □ Yes □ No

Was the birth assisted? □ Yes □ No

If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____

Duration of Birth:
Was the delivery normal? □ No □Yes If no, what complications were there at birth?

Birth Weight _____ Birth Length _____

Growth and Development
Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain:

Were there any developmental delays? □ Yes □ No

Do his/her sleeping patterns seem normal? □ Yes □ No

Is there a history of family conditions or diseases? □ Yes □ No

Do the child's siblings have any health problems? □ Yes □ No If yes, describe:

At what age did the child:
Lift head_____
Roll over_____
Sit up_____
Teethe_____
Crawl_____
(If your child did not crawl, please indicate what movement they did before walking_____
Walk_____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors
During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No
3. Take supplements/vitamins? □ Yes □ No 4. Take drugs? □ Yes □ No If yes, what? _____
5. Become ill? If so, how? 6. Receive ultrasounds? □ Yes □ No If yes, how many?_____ 7. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long? _____ weeks months years

Did your child receive vaccinations? □Yes □ No If yes, which ones? _____
Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why?

Any smokers at home? □ Yes □ No If yes, how much? _____

Psychological Stressors
Any difficulties with lactation? □ Yes □ No Did your baby have a preference to one side? □ Yes □ No

Any problems bonding? □ Yes □ No

Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour problems? □ Yes □ No If yes, what?

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify:

Did your child go to daycare? □ Yes □ No From what age? _____ yrs

Physical Stressors
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.
Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) □ Yes □ No
If yes, please explain _____
_____
_____
Any evidence of birth trauma to the infant?
□ bruising
□ stuck in birth canal
□ respiratory depression
□ odd shaped head
□ fast or excessively long birth □ 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? _____

Traumatic Stressors
Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal
□ Fast and/or excessively long birth □ Respiratory Depression □ Cord around neck □ Other

Any falls/accidents during pregnancy? □ Yes □ No

Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe:

Any hospitalizations? □ Yes □ No Please explain:

Does your child play sports? □ Yes □ No
Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx.

Hours spent at play per week? _____ hrs

At Shiozawa Wellness Centre, my priority and commitment to you is to give you the best chiropractic care possible to help you achieve your health goals. My service to you is to provide quality care, knowledge, and the highest skill possible. This involves working together to create a specific care plan along with coaching you to allow you to achieve a high state of wellness.

By choice, I am not registered in the UK as a chiropractor. Because the General Chiropractic Council, the British regulatory body for chiropractic, has not recognised any non-EU qualifications, I may not in the UK describe myself as a "chiropractor" (per Chiropractors Act 1994, s.32).
But in 1997 I graduated from Life University in Georgia with a Doctorate of Chiropractic, and since 1998 have been fully Board Certified as a chiropractor, licensed in both Minnesota and New York.

Please sign here to acknowledge understanding and accept this disclaimer:

_____ Date _____