SHAW CHIROPRACTIC
FAMILY WELLNESS CENTRE

Your potential for wellbeing lies within. Our purpose is to set it in motion.

Confidential Child Health History (ages 12 and under)

Date: _____ Sex: ☐ Male ☐ Female

Name: _____ Date of Birth: ____/____/_____ Age: _____
MM DD YY

Street:_____ City:_____ Postal Code:_____

Pediatrician/Health Care Provider: _____

Has your child ever received chiropractic care? ☐ Yes ☐ No

If yes, when and where?_____

Referred by?_____

CONTACT INFORMATION FOR PARENT/GUARDIAN:

Parent/Guardian:_____ Email:_____

Phone: Home: _____ Cell:_____

About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize our optimum health potential. Please take a moment to fill out these questions so that we can better understand your child's overall health. We can then develop an appreciation for the layers of damage to your child's spine and nervous system that may be blocking their body's innate ability to be healthy.

Welcome to Our Office,

Dr. Greg Shaw, DC
Dr. Steve Bako, DC

Events and Habits

NEONATAL TO NOW: Many problems have their roots in early spinal and/or neurological damage.

Yes	No		Patient Comments
		BIRTH	_____
☐	☐	Was it a vaginal birth?	_____
☐	☐	Assisted birth (forceps/vacuum extraction/c-section)?	_____
☐	☐	Mother given medication prior or during delivery?	_____
☐	☐	Complications at birth?	_____
		GROWTH AND DEVELOPMENT	
☐	☐	Developmental milestones met on time?	_ _____
☐	☐	Sleeping patterns seem “normal”?	_____
☐	☐	Any surgeries or prolonged medications?	_____
☐	☐	Any notable falls/injuries?	_____
		CHEMICAL STRESSORS	
☐	☐	Breast-fed? How long?	_____
☐	☐	Formula introduced at age _____	
☐	☐	Introduced cow’s milk at age _____	
☐	☐	Food/juice intolerance? Type: _____	
		Began solid foods at age _____	
☐	☐	Picky eater? _____	
☐	☐	Did the mother smoke during pregnancy?	
☐	☐	Illness of the mother during pregnancy?_____	
☐	☐	Supplements/drugs during pregnancy? _____	
☐	☐	Drugs during pregnancy: _____	
☐	☐	Exposure to ultrasound? How many and when?_____	
☐	☐	Invasive procedures (amniocentesis, CVS) _____	
☐	☐	Any pets at home?_____	
☐	☐	Any smokers at home? How much? _____	
☐	☐	Vaccinations: Which ones and any reactions? _____	
☐	☐	Antibiotics? Number of courses to date?_____	
		PSYCHOSOCIAL STRESSORS	
☐	☐	Difficulties with lactation?	_____
☐	☐	Problems bonding?	_____
☐	☐	Behavioural problems? Onset?	_____
☐	☐	Daycare? Age started?	_____
☐	☐	Night terrors/sleep walking?	_____
		Sleep posture: ☐ Side ☐ Back ☐ Stomach	
		Average number of hours of television/computer/week	_____

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Yes	No	TRAUMATIC STRESSORS	
☐	☐	Traumas during pregnancy (falls, accidents)?	_____
☐	☐	Was your child ever in a motor vehicle accident?	_____
☐	☐	Notable falls/injuries?	_____
☐	☐	Any hospitalizations?	_____
☐	☐	Any surgeries?	_____
☐	☐	Any head injuries/broken bones?	_____
☐	☐	Sports played? Began at age: _____ Hours/week played?	_____
☐	☐	Backpack weight seems excessive?	_____

Symptoms and Ill Health

As the years go by and the layers of damage to your child's spine and nervous system increase, it is common to begin experiencing symptoms and have random bouts of ill health until they are brought to their present state of health.

Reason for consulting our office: _____

What do you hope to gain from care at this office? _____

If you have a specific concern, please describe briefly. If no, please proceed to next page.

_____

_____

How and when did this problem start? _____

_____

Is the problem ... ☐ constant ☐ intermittent ☐ no change

Is the condition worse ... ☐ in the A.M. ☐ in the P.M. ☐ worse with movement

Is it interfering with ... ☐ sleep ☐ daily routine
☐ other _____

Is condition getting progressively worse? ☐ Yes ☐ No

Have X-rays, MRI or CAT been taken of the area? ☐ Yes ☐ No When? _____

Have any of the following been tried to solve the problem?

☐ Ice	☐ Heat	☐ Stretching/exercise	☐ Vitamins
☐ Medications	☐ Rubs or gels	☐ Diet changes	☐ Stress reduction
☐ Aspirin or Tylenol	☐ Surgery	☐ Chiropractic care	☐ Massage/Body work
☐ Naturopathic care	☐ Acupuncture	☐ Other: _____	

Has your child ever or do they presently suffer from any of the following symptoms?

Past	Now		Past	Now	
☐	☐	Headaches	☐	☐	Nervousness
☐	☐	Frequent colds	☐	☐	Nose/sinus problems
☐	☐	Fatigue	☐	☐	Dizziness/balance issues
☐	☐	Allergies	☐	☐	Asthma/lung problems
☐	☐	Skin problems	☐	☐	Fainting
☐	☐	Depression	☐	☐	Tension
☐	☐	Irritability	☐	☐	Frequent nausea
☐	☐	Cold feet/hands	☐	☐	Heart problems
☐	☐	Bladder problems	☐	☐	Menstrual problems
☐	☐	Diarrhea	☐	☐	Constipation
☐	☐	Digestive disorders	☐	☐	Kidney problems
☐	☐	Numbness or pins & needles in arms/legs			
☐	☐	Other? _____			

Is your child currently taking any medications or treatments? Do they experience any side effects from these medications/treatment? Please describe.

_____

FAMILY HISTORY: (include parents & siblings)

Does any other family member experience any of the above listed symptoms? ☐ Yes ☐ No
If yes, which ones? _____

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other _____
Father's Side	☐	☐	☐	☐	☐	
Mother's Side	☐	☐	☐	☐	☐	
Siblings	☐	☐	☐	☐	☐	

*Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then **Corrective Care** begins, which corrects the years of damage that occurred when there were few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your child's report of findings. Then you'll be able to begin a course of care that fits your health goals.*

I understand that the purpose of today's visit is to determine if your child is a candidate for chiropractic care. I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____

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