Toxic Stressors

Does (did) the mother or father smoke? How much?

During the pregnancy did the mother drink? How much?

During the pregnancy did the mother take drugs/medications? What and how often? (explain):

During the pregnancy did the mother take vitamins/supplements? What and how often? (explain):

During the pregnancy did the mother have any ultrasounds? How many and for what reason? (explain):

During pregnancy did the mother have any investigative procedures performed and why? (i.e. amniocentesis, CVS, cord sampling) (explain):

Was the child breast fed? How long? Any problems? (explain):

Was formula introduced? What kind and at what age? (explain):

Was cow's milk introduced? At what age? (explain):

When were solid foods introduced? What type? Any reactions/sensitivities/allergies to food noted? (explain):

Describe current diet:	1	2	3	4	5	6	7	8	9	10
(Scale from 1 - 10)	All junk			Some junk, some veggies				Organic, no junk, 10 - 15 servings of veggies		

Current supplements:

Current medications:

Current water intake:

Were any medications/antibiotics used by the child? What and when? (explain):

Vaccinations given and at what ages (explain):

Any reactions noted to the vaccinations? (explain):

Any Pets at home? What? (explain)

Psychosocial Stressors

Were there any problems with: bonding? ☐ Yes ☐ No, Behaviour? ☐ Yes ☐ No, Night terrors, sleep walking, sleep, child care? (explain):

Do you feel that your child's social and environmental development is normal for their age? ☐ Yes ☐ No

Is the child at home, daycare, school, (other)?

How would you describe the child's behaviour and performance at school?

Describe the child's sleep pattern:

What are your child's favourite activities:

Authorization for care of a minor

I hereby authorize this office and it's doctors to administer care to my son/daughter as they feel necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Patient signature: Today's Date: Witness:

Welcome to Meyer Chiropractic Health Centre

Confidential Pediatric/Youth Patient Health Record

Confidential Patient Information

Child's Name: | Last Name:

Parent's Name(s)/Guardian: | Name of Person filling out this form:

Sibling's Names and ages:

Address: | City:

Prov.: | Postal Code: | Email Address:

Home Telephone: | Work Telephone: | Cell Telephone:

Date of Birth: | ☐ Male ☐ Female

Referred by: | Name of Medical Doctor:

Has your child ever received Chiropractic care? If yes, when and by whom?

Were there any X-Rays taken? If yes, when?

Approx. date of last medical/health visit and reason:

Present Health Concerns

Please answer and comment on the following questions to the best of your ability.

☐ Major: (explain)

☐ Minor: (explain)

When did this problem begin?

Is it worsening or improving?

What makes it worse?

What makes it better?

Does it interfere with the child's sleeping, daily routine, eating?

Other members of the family seen for this concern? Results?

Please note any health concerns with:

Father	Mother
Father's close relations	Mother's close relations

Siblings

How would you describe your child's general state of health?

☐ Good ☐ Fair ☐ Poor

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Physical Stressors

Any trauma to mother during pregnancy? (i.e. falls, accidents, medications?) (explain):

Was the child born:

☐ Full-term ☐ Premature (weeks) ☐ Late (weeks)

Any evidence of birth trauma to the infant? (i.e. Bruising, stuck in birth canal, breech, vacuum, forceps, respiratory distress, odd shaped head, twins, excessively fast or long birth, cord around neck, hip distortion, difficulty breastfeeding) (i.e. harder on one side), other: (explain):

Does/Did the child use a jolly jumper? How often and for how long:

According to the National Safety Council, approximately 50% of children fall from a high position during their first year of life (i.e. from couches, beds, change tables) Did this occur with your child? (explain):

Any traumas resulting in: major bruises, cuts, stitches, fractures, hospitalizations or surgeries? (explain):

Involved in any high impact sports/acitivities? What and at what level? (i.e. recreational, competitive rep, professional) (explain):

Does your child use a school backpack? Is it heavy or light? (explain):

Has your child ever been involved in a car accident? (explain):

Has your child ever been seen on an emergency basis? (explain):

☐ Yes ☐ No Prior surgeries? (Please list type of surgery, along with date received)

Does the child have postural assymmetries? i.e. (tilts head, holds one leg up, holds head to one side):

Are you aware of any assymmetries present? i.e. (one side of body larger, or more short than the other)