ROCK FAMILY
CHIROPRACTIC
Restoring Our City of Kingston

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File no.___________ **PERSONAL HEALTH PROFILE (CHILD)**

Name: Date:

Home address: City: Postal Code:

Email address: Home Phone: Parent(s) work phone: ( ) ( )

Gender: Present length: Parent(s) cell phone: M☐ F ☐Weight: ( ) Date of Birth: Age: Parent(s) names:
MM DD YY

Extended Health Insurance: $ Participation/Year: Renewal Date: Yes No Company:
☐ ☐
How were you referred to our office? Have you ever received chiropractic care before? Yes☐No ☐Who was the doctor and where?
# of years under care?

Family Doctor's name: Phone number:
( )

Do you have siblings? What are their names and ages?
Yes☐ No ☐

A) HEALTH CONCERNS

Is this visit for a wellness checkup? Yes☐ No ☐If this is for a specific concern, proceed below. Reason for visit:

Date of onset: Indicate whether onset was: Duration of problem: Sudden/Gradual/Due to event
Pattern of problem: Prior occurrence or episodes:
Constant/Intermittent/Occasional/Cyclical
Effects of problems on body function/daily activities:Initiating/Aggravating/Relieving factors:

If you don't get the problem corrected, do you think it will get worse in the next ☐1 year ☐2 years ☐5 years B)

HISTORY OF BIRTH

(Please circle all that apply) Type of delivery: Hospital/Birthing center/Home/Medical/Midwife Duration of gestation: Complications at birth? If yes, list below:
# of weeks:
Duration of birth: APGAR score
Birth:
5 minutes: Birth weight: Birth length:

Check off the following that describe your child's birth.

long and/or difficult forceps vacuum extraction caesarean epidural breech

induced natural (no drugs/pulling/excessive force)

C) GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? YES/NO Please explain:

Has your child met their developmental milestones at the appropriate times? YES/NO Please explain:

Is their sleeping pattern normal? List any health problems (Cancer, Diabetes, Heart disease, etc.) YES/NO Please explain: on father/mother's side of family or in siblings:

D) STRESSORS

Since problems that arise are related to many types of stressors and traumas, please fill in the following information as it is very important to us:

CHEMICAL PSYCHOSOCIAL TRAUMATIC

Was the baby breast-fed? YES/NO Any difficulties with lactation, latching Any traumas during pregnancy (falls, or sucking? YES/NO accidents)? YES/NO Please explain:

Duration:

Food Intolerance? YES/NO Any behavioural problems? YES/NOAny evidence of birth trauma: Type: Onset: (E.g. bruises, odd shaped head, stuck in birth Any illness of the mother during Any night terrors, sleep walking, canal, fast or excessively long birth pregnancy? difficulty sleeping? YES/NO respiratory depression, cord around neck) Specify:

Any supplements of mother during pregnancy?

Any drugs taken during Does your child seem normal for their Any falls from couches, beds, change tables? pregnancy? age? YES/NO Please explain: YES/NO Please explain:

Any exposures to ultrasound? YES/NO Any traumas with bruising, cuts, stitches, If so, how many and what was the fractures? YES/NO Please explain: medical reason?

Any Invasive procedures? Any hospitalizations? YES/NO (E.g. Amniocentesis, CVS) Please explain:

Any smokers in the home? YES/NO

Any vaccinations? YES/NO Any surgeries or organs removed? YES/NO

Which ones and any reactions: Please explain:

Any antibiotics? YES/NO Any history of ear infections, regular colds, Which ones and any reactions: strep throat, croup, pneumonia or bronchitis? YES/NO Please explain:

Total number of courses of antibiotics: