FAMILY FIRST CHIROPRACTIC

6788 Thorold Stone Road
Niagara Falls, Ontario
L2J 1B4

Dr. Heather Robson-McInnis, D.C.

(ph) 905-358-8717
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PARENT / CHILD HEALTH HISTORY

Note: Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood, could be the unsuspected cause of many health problems in children.

Name of child: ____

Address: ____________________________ City: ______________________

Postal Code: ________________

Phone Number ________________________ Sex of the child: Male / Female

Date of Birth: ________________________ Age of the child: __________

Email: ______________________________

Name of Parent: ________________________

Address (if different from child): ______________________________________

Does or did your child suffer any health problems such as:
(please circle all that apply)

Headaches	Irritability	Diarrhea
Allergies	Hyperactivity	Constipation
Ear problems	Frequent colds	Colic
Sleeping disorders	Flu	Rashes
Breathing problems	Digestive problems	Milk or lactose intolerance
Fatigue	Meningitis	Bed wetting

Other:____

____

____

Has your child had any adverse reactions to any vaccinations? If so, please list what vaccination, the age of your child at the time and what reactions occurred.

____

____

____

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PARENT / CHILD HEALTH QUESTIONNAIRE cont'd

Regarding your child today:
(please check those that apply)

Is your child accident prone? ________

Has the child had any falls down the steps? _______

Has your child ever fallen from heights over 2 feet? ______

Has your child ever been involved in a motor vehicle accident? ________

Has your child ever been hospitalized or had surgery?______

Has your child had a scoliosis exam? _______

Is your child hyperactive? _______

Does your child have learning disorders?_______

Does your child have sleeping difficulties? ______

Poor posture? _________

Does your child have any problem associating with friends? ________

Is your child nervous, or has anyone suggest that your child was nervous? ________

Does your child show any signs of nervousness, twitching, or excessive talking to themselves? ________

If you could improve one aspect of your child's health or behaviour, what would it be?

____

____

Does your child suffer from: Allergies ____ Asthma ____ Headaches ____

Has your child every had any broken bones or sprain injuries? __________

Is your child on any medication? __________

Regarding pregnancy:

Were you on medication? ____

Did you smoke or consume any alcoholic beverages? ___________________________

Was there back pain? ____

Approximately how long was labour? ____

Were you physically ill during your pregnancy? (e.g. Colds, flu, allergies, German measles etc.) if so, what?

____

____

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PARENT / CHILD HEALTH QUESTIONNAIRE cont'd

Regarding labour:

Was it chemically induced? ________

Doctor assisted? _______

Was a C- section performed? ______

Were forceps used? _______

Did the doctors have hands on the infant? ________

(95 % of all infants were born with hands on or forceps)

Were you lying down? ______

Was the baby premature? _______

If so, what was his/her age and weight? __________________________

Consent to treatment

I, the child's legal parent or guardian, hereby request and consent to the performance of chiropractic adjustments and procedures, including various modes of diagnostic testing, on my child by the doctor of chiropractic name below:

___________________________________	___________________________________
Print Child's Name	Signature of Parent/Guardian
___________________________________	___________________________________
Witness	Date

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