JOHNSON CHIROPRACTIC CLINIC
102-130 Sproule Rd
Perth, ON ~ K7H 3C9
(613) 264-2402 ~ fax (613) 264-2410

Child Health Profile
(age 0 - 10)

Patient # __________

Date: ____________________

Name: ______________________________

Address: ______________________________Telephone # ______________________Date of Birth __________

Referred by _____________________

Who is your family doctor ____

Doctor's address __________________________ Last visit to family doctor_____________________________

Previous Chiropractor: Name and last visit ____

Present height ______________ Present weight ________________

Chief health concerns: ____

List other care undergone for this complaint: (*including medications)*______________________________________

Date of onset ____/____/____ Onset was: Sudden/Gradual/Associated with an event

Duration of problem (episode) ___Minutes / ___ Hours / ___Days / ___Months / ___Years

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Aggravating factors:____

Relieving factors: ____

Prior occurrence of episodes: ____

OTHER HEALTH CONCERNS: ____

HISTORY OF BIRTH: *(please check one)*

Hospital☐ Birthing centre☐ Home☐

Duration of Gestation ___ Weeks

Assisted birth: No☐ Yes☐ If yes... forceps☐ vacuum extraction☐ c-section☐ induced labour☐

Medications delivered to mother at birth? No☐ Yes☐ If yes what? ______________________________________

Duration of birth: ____

Complications at birth: No☐ Yes☐ If yes...explain ____

APGAR at birth _________________ After 5 minutes ____________________________

Birth weight ____________________ Birth length _______________________________

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? Yes☐ No☐ if no explain _________________

At what age did the child:

Respond to sound ____________ Follow an object ____________ Hold up head ____________

Vocalize ____________________ Sit alone __________________ Teeth _________________

Crawl ______________________ Walk _____________________

Do sleeping patterns seem normal to you?: Yes☐ No☐ Explain ___________________________

Is there a Family History of: (check all that apply ✓)

	Heart Disease	**Stroke**	**Cancer**	**Arthritis**	**Diabetes**	**Other**
Mother	☐	☐	☐	☐	☐	☐ ___________
Father	☐	☐	☐	☐	☐	☐ ___________
Brother(s)	☐	☐	☐	☐	☐	☐ ___________
Sister(s)	☐	☐	☐	☐	☐	☐ ___________

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

Was this baby breast-fed? No☐ Yes☐ if yes how long? ___________________________________

Formula introduced at age _____________ Type of formula used ___________________________

Cow's milk given at age _______________

Began solid foods at age _______________ Type ____

Age of commercial baby food introduction __________ Type ______________________________

Food/juice intolerance No☐ Yes☐ Type ____

During pregnancy did the mother: Smoke? No☐ Yes☐ Drink? No☐ Yes☐

Any illness of the mother during pregnancy: ____

Any supplements for mother during pregnancy: ____

Any drugs taken during pregnancy: ____

Any exposures to ultrasound: Yes☐ No☐ If so, how many and what was the medical reason?

____

Any invasive procedures (amniocentesis, CVS): ____

Any pets at home: No☐ Yes☐ ____

Any smokers in the home: No☐ Yes☐ if so, how much? ___________________________________

Any vaccinations: which ones and any reactions: ____

Any antibiotics: No☐ Yes☐ explain ____

Total number of courses of antibiotics to date: ____

Any difficulties with lactation: No☐ Yes☐ ____

Any difficulties with bonding: No☐ Yes☐ ____

Any behavioural problems: No☐ Yes☐ ____

Any night terrors, sleep walking, difficulty sleeping: No☐ Yes☐ specify ____________________

Age of child when began daycare: ____

Average number of hours of television/week ____

Does your child seem normal for his/her age Yes☐ No☐ explain __________________________

Any traumas during pregnancy (falls, accidents) ____

Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other ____

Any falls from couches, beds, change tables ____

Any traumas with bruising, cuts, stitches, fractures _______________________________________

Any hospitalizations: No☐ Yes☐ explain ____

Any surgeries or organs removed ____

Sports played and age began ____

Email: ____

I give **express consent** to Johnson Chiropractic Clinic for email contact such as birthday greetings and our newsletter and to notify me of special offers and events. I can withdraw my consent at any time. This consent does not apply to statements, reminders or appointments lists, these notifications are covered under implied consent and do not need express consent.

_____________________________________ _________________________________

Signature of Parent (or legal guardian) *Date*

PATIENT ALLERGY/SENSITIVITY SURVEY

Check any of these you believe may be causing your child problems:

□ Shell Fish
□ Anxiety/Stress issues
□ Fruits / Berries, Nuts
□ Bed Wetting
□ Eggs, Grains
□ Animal Dander, Feathers, Fur
□ Nightshades (tomatoes, potatoes, peppers)
□ Fabrics, Upholstery, Plastics
□ Skin issues, Acne, Eczema, Psoriasis
□ Laundry Detergents, Softeners
□ Dairy (milk, cheese, yogurt, etc.)
□ Asthma, Breathing issues
□ Lack of Energy
□ Chocolate (caffeine)
□ Metals ___________________________
□ Perfumes, Candles, Oils, Shampoo, Makeup
□ Nutritional Supplements/Herbal Remedies
□ Environmental (pollen, grass, Trees, mold)
□ Sleep Issues
□ Stinging Insects
□ Seasonal Allergies
□ Focus, Concentration, Memory Issues
□ Emotional Upset/Traumas___________
□ Chemicals, Latex__________________
□ Other ___________________________
□ Digestive Issues, Bloating, Gas

Please answer the following questions about the above substances:
Which of the above causes your child the most trouble? ____________________________
____

On the 1-10 scale below, how would you rate your child's discomfort from this allergy/sensitivity, when it's at its worst?
Mild 1 2 3 4 5 6 7 8 9 10 **Severe**

How long has your child been suffering with this allergy/sensitivity problem?
_____weeks _____months _____years

How does this allergy/sensitivity condition affect your child's ability to perform daily tasks (check one)
□ No major impact – I get along fine
□ It bothers me – but I just carry on
□ It bothers me – slows me down, sometimes
□ It's an occasional problem – but when it's bad, it's really bad
□ It bothers me all the time – it can stop me from doing things I want to do
□ I'm desperate – I need help

Would you like to eliminate or reduce this allergy/sensitivity this problem? □ Yes □ No

We offer an advanced program to reduce or eliminate many of the allergies and sensitivity issues you and/or your family members may be experiencing. Please let us know if you would like to receive more information.