JOHNSON CHIROPRACTIC CLINIC
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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 _____

Name:_____

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: _____

Name:_____

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*