DR. MICHAEL ENGEL
FAMILY CHIROPRACTOR

OPTIMAL HEALTH
FOR FAMILIES

PEDIATRIC HEALTH HISTORY

Today's Date:________________

Patient's Name: ______________________________ Date of Birth (dd/mm/yyyy): ____________________ (Age____)

Address: ____________________________________ Sex: ❑ M ❑ F MB Health Card 6 digit #: ________________

City: _____________ Prov.:____ Postal: ________ 9 digit #: _________________

Phone: (H) ______________ (W/C) _____________ Mother's Name: ____

Email: ______________________________________ Father's Name: ____

Referred By: _________________________________ Pediatrician's Name: ____________________________________

Many health challenges people face later in life may have their origins in stresses from the developmental years, some even starting at birth.

Circle All That Apply ***Patient*** ***Comments/Details***

1. In-utero – Pregnancy – If Yes, please write details

Complications during pregnancy? Y / N ____
Ultrasounds used during pregnancy? Y / N ____
Medications used during pregnancy? Y / N ____
Cigarettes/Alcohol used during pregnancy? Y / N ____
Trauma to mother during pregnancy? Y / N ____

2. Was Your Child's Birth Traumatic? – If Yes, please write details

Long delivery? Y / N ____
Difficult delivery? Y / N ____
Forceps / vacuum extractor? Y / N ____
Caesarian section? (planned/emergency) Y / N ____
Breach/cephalic? Y / N ____
Mother given drugs/epidural during birth? Y / N ____
Induced labour? Y / N ____

3. Growth and Development (Childhood Years: Ages 0-17 years) – If Yes, please write details

Did/does your child ever...
Utilize Chiropractic Care (prior to today)? Y / N ____
If Yes, date of last visit & reason ____
Fall while learning to walk? Y / N ____
Have any other falls or accidents? Y / N ____
(eg: bike, skating, playground, skiing, horseplay, etc) ____
Have surgery? (dates, type) Y / N ____
Have recurrent childhood illness/sickness? Y / N ____
Take drugs (eg. antibiotics, vaccines)? Y / N ____
doses of Antibiotics last 6 months: ____________ total during his/her lifetime___________
doses of Other Prescription Medications last 6 months: ____________ total during his/her lifetime___________
vaccinations last 6 months: ____________ total during his/her lifetime___________
Seen on an emergency basis? Y / N ____
Experience other traumas/ stress? Y / N ____
Involved in any high impact sports? Y / N ____
(eg: soccer, football, gymnastics, hockey, martial arts?) ____
Sports injuries? (dates, injury) Y / N ____
Have sleeping trouble? Y / N ____
Have high emotional stress? Y / N ____
Allergies? (please list) Y / N ____
Take nutritional supplements? (please list) Y / N ____

According to statistics, approximately 50% of children fall head first from a high place during their first year of life (eg: a bed, change table, down stairs, etc). Was this the case with your child?
Y / N ____

Has your child experienced any of the following:

- ❑ Ear Infections
- ❑ Asthma / Allergies
- ❑ Colic
- ❑ Headaches
- ❑ Scoliosis
- ❑ Digestive Problems
- ❑ Bed Wetting
- ❑ Growing Pains
- ❑ Back / Neck Pains
- ❑ ADHD
- ❑ Seizures
- ❑ Chronic Colds / Flus
- ❑ Recurring Fevers
- ❑ Temper Tantrums
- ❑ Car Accident
- ❑ A Big Fall

❑ Other ____

Date of last visit to Pediatrician: ________________ Reason: ____

ADDRESSING THE REASONS THAT BROUGHT YOUR CHILD TO OUR OFFICE

Reason for your child's visit today: ❑ Healthy spine check-up ❑ ________________________________

____

Pain or problem started how and when? ____

Pain or problem occurred before? ____

What activities make your child's condition / pain worse? ________________________________

What activities make your child's condition / pain better?________________________________

How long has it been since your child really felt good? __________________________________

If your child has pain, is it… ❑ sharp ❑ dull ❑ radiating ❑ constant ❑ intermittent
❑ mild ❑ moderate ❑ mod-severe ❑ severe

Since it began, is it… ❑ about the same ❑ variable ❑ getting better ❑ getting worse

What time of day is it worst? ❑ waking ❑ at school ❑ evening ❑ at night ❑ variable ❑ constant

Does it interfere with… ❑ school ❑ sleep ❑ walking ❑ sitting ❑ exercise ❑ other____________________

As a result of my child's Chiropractic Care, I would like to him / her to: (Please check all that apply)

- ❑ ***Feel better quickly***
- ❑ ***Have a healthier spine***
- ❑ ***Have a healthier body by keeping my nerve system healthy***
- ❑ ***Live a healthier, more active lifestyle***

The above stated is true. I hereby authorize this office and its Doctor(s) to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office when the services are rendered. I consent to my child being treated in an open area and I understand that a private room is available should I or they request one.

______________________________ ____________________
Parent or Guardian Signature Date

To help share chiropractic miracles and celebrate special occasions, I consent to my child's photograph and name being used in the office for recognition.

______________________________ ____________________
Parent or Guardian Signature Date