



Child's Personal Information

Name _____ Date _____
 Address _____ City _____ Province _____
 Postal Code _____ Date of Birth: D ___ M ___ Y _____ Age _____
 Home Phone _____ Cell Phone _____ E-mail _____
 Where do you prefer to be contacted? Home ___ Work ___ Cell ___
 Mother: _____ Father: _____
 Whom may we thank for referring your child to Vibrant Life Chiropractic? _____

Check the phrase that most represents your child's reason for care:

Wellness Prevention Feel good Symptom Relief

Health Concerns

(If there are no current concerns and this assessment is to ensure optimum health and functioning, skip to next page)

Concern	Severity 1=mild 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is the symptom present?

Is this condition interfering with your child's:

School Behaviour Sleep Daily Routine Sports/Activities

Other: _____

Is there a family history of similar concerns? Yes No

Please explain _____

What other health practitioners has your child seen? (Mark P for past or C for current)

Chiropractor Medical doctor Naturopath Physiotherapist Massage therapist

Other _____

What have you done for this condition? Was it of benefit? _____

Often seemingly unrelated symptoms can tell us information about the function of the nervous system and overall health:

(Please check if your child has had any of the following – past or present)

- | | | |
|--|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> bloating/gas |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> asthma | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> fainting | <input type="checkbox"/> urinary problems | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> constipation | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> irritability | <input type="checkbox"/> diarrhea | <input type="checkbox"/> radiating pain |
| <input type="checkbox"/> depression | <input type="checkbox"/> weight loss | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> weight gain | <input type="checkbox"/> reduced mobility |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> fevers | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> numbness in feet |
| <input type="checkbox"/> poor coordination | <input type="checkbox"/> frequent colds | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> sore throats | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> allergies | |

Other: _____

PHYSICAL HEALTH:

Please list any childhood falls/accidents

Type: _____	Age: _____	Hospitalized? Y N
Type: _____	Age: _____	Hospitalized? Y N
Type: _____	Age: _____	Hospitalized? Y N

Please list if your child has had any surgeries:;

Type: _____	Date: _____	Reason: _____
Type: _____	Date: _____	Reason: _____
Type: _____	Date: _____	Reason: _____

Pregnancy History

Any traumas / illnesses? Yes No _____

Did the mother:

Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
Take medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Labour History: Please check all that apply:

Drug induction Epidural Antibiotics during labour

Duration of labour: _____ Duration of pushing phase: _____

Was there any assistance used?

forceps vacuum / suction manual traction from caregiver c-section

Were there any complications during birth? Yes No

Please explain: _____

Infant health: Please check all that apply:

Was there any evidence of trauma following birth?

bruising odd shaped head stuck in birth canal respiratory distress
 excessively fast birth prolonged labour

Did your child experience any of the following:

Incubation How long? _____
 Separation after birth? How long? _____
 Colic
 Digestive problems
 Nursing difficulties
Other: _____

Was your child breastfed? Yes No For how long? _____

Sports and Activities

Any sports? _____ How often? _____

Does your child carry a backpack? Yes No Heavy Light

Hours per week watching TV? 0-10 10-20 20-30 30-40

Hours per week on the computer? 0-10 10-20 20-30 30-40

BIOCHEMICAL HISTORY

Please list ALL drugs your child currently takes or have taken in the past 6 months:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Please list all nutritional vitamins or homeopathic remedies your child currently takes:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Has your child been vaccinated? Yes No Age of first vaccination: _____

If so, has he/she had a reaction to vaccination? Yes No

If so, please explain: _____

