# Child Health Profile

**Date:____/____/____**

Child's Last Name:_____ Child's First Name:_____

Date of Birth: DD / MM / YY AGE_____ Parent's Name:_____

MHSC#(6 digit)_____ PHIN#_____ Sex: M F Insurance: YES □ NO □

Address:_____ City/Prov.:_____ Postal Code:_____

Home Phone:_____ Business Phone:_____ Cell:_____

Email:_____ Referred by: _____

## GENERAL INFORMATION

Has your child ever been to a chiropractor before? YES □ NO □

Were you pleased with your care YES □ NO □

What is your primary reason and/or health concern for coming today:_____

_____

Have the parent's of the child ever received chiropractic care before? YES □ NO □

## BIRTH STRESS

Was the mother ill prior to being pregnant with the child receiving care today? YES □ NO □

Was the pregnancy difficult? YES □ NO

Please check all that apply *DURING THE PREGANCY*.

Mother was ill □ Fell/Accidents/Injuries □ Mother was knocked unconscious □

Please check all that apply *DURING THE CHILD'S BIRTH*.

Labour was chemically induced □ Mother was Conscious □ Mother was Unconscious □

Cord around the Neck □ Forceps/Suction used □ C Section □ Breech □

Was the pregnancy…At Home □ In a Birthing Center In a Hospital □ Other □

In regards to feeding, was the child…Bottle Fed □ Breast Fed □

Is the child currently experiencing or have they ever experienced any of the following: (Please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Headaches □ | Allergies □ | Fatigue □ | Irritability □ | Frequent Colds □ | Flu □ |
| Ear Infections □ | Breathing Problems □ | | Hyperactivity □ | Bloody Noses □ | Colic □ |
| Bed Wetting □ | Lactose Intolerance □ | | Diarrhea □ | Meningitis □ | Asthma□ |
| Constipation □ | Digestive Problems □ | | Rashes □ | Sleeping Disorder □ | |

Has the child ever experienced the following: (Please check all that apply)

| | | |
|---|---|---|
| Been knocked unconscious □ | Used Crutches or Corrective Braces □ | Accident Prone □ |
| Fallen down steps □ | In a Car Accident □ | Been Hospitalized □ |
| Broken Bones □ | Sprain Injuries □ | |

Has the child ever been: on medications □ vaccinated □

Is your child active in any particular sports? YES □ NO □

If yes, please list which ones:_____

Does the child have any of the following:

Hyperactivity □ Learning Disorder □ Poor Posture □ Nervous/Anxiety □

Please circle one of the below to rate your child's physical, mental, and emotional health?

*Physical Health*

Getting worse Getting Better Poor Fair Good Excellent

*Mental Health*

Getting worse Getting Better Poor Fair Good Excellent

*Emotional Health*

Getting worse Getting Better Poor Fair Good Excellent

For the stresses listed below, please indicate the severity:

| **STRESSES** | **CURRENTLY** | | |
|---|---|---|---|
| Family | Low □ | Mid □ | High □ |
| School | Low □ | Mid □ | High □ |
| Stress of commuting | Low □ | Mid □ | High □ |
| Loss of a loved one | Low □ | Mid □ | High □ |
| Stress of being Sick | Low □ | Mid □ | High □ |
| Change in Lifestyle | Low □ | Mid □ | High □ |
| Change in School | Low □ | Mid □ | High □ |
| Abuse of any kind | Low □ | Mid □ | High □ |

## OUR SERVICE

Our service is very important, please let us know what you are hoping to receive from this care.

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