Dr. Clarise Chan, B.Sc., D.C.

PERSONAL HEALTH PROFILE (CHILD)

File no.: _____

Name:			Date:
Home address:		City:	Postal Code:
Email address:		Home Phone: ( )	Parent(s) work phone: ( )
Gender: M ☐ F ☐	Present length: Weight:		Parent(s) cell phone: ( )
Date of Birth: MM DD YY	Age:	Parent(s) names:	
Extended Health Insurance: Yes ☐ No ☐ Company:		$ Participation/Year:	Renewal Date:
How were you referred to our office?	Have you ever received chiropractic care before? Yes ☐ No ☐ # of years under care?	Who was the doctor and where?	
Family Doctor's name:	Phone number: ( )		
Do you have siblings? Yes ☐ No ☐	What are their names and ages?		

A) HEALTH CONCERNS

Is this visit for a wellness checkup? Yes ☐ No ☐ If this is for a specific concern, proceed below.

Reason for visit:		
Date of onset:	Indicate whether onset was: Sudden/Gradual/Due to event	Duration of problem:
Pattern of problem: Constant/Intermittent/Occasional/Cyclical	Prior occurrence or episodes:	
Effects of problems on body function/daily activities:	Initiating/Aggravating/Relieving factors:	

If you don't get the problem corrected, do you think it will get worse in the next 1 year ☐ 2 years ☐ 5 years ☐

B) HISTORY OF BIRTH

(Please circle all that apply)		Type of delivery: Hospital/Birthing center/Home/Medical/Midwife	
Duration of gestation: # of weeks:		Complications at birth? If yes, list below:	
Duration of birth:	APGAR score		
	Birth: 5 minutes:	Birth weight:	Birth length:

Check off the following that describe your child's birth.

☐ long and/or difficult ☐ forceps ☐ vacuum extraction ☐ caesarean ☐ epidural

☐ breech ☐ induced ☐ natural (no drugs/pulling/excessive force)

C) GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? YES/NO Please explain:	
Has your child met their developmental milestones at the appropriate times? YES/NO Please explain:	
Is their sleeping pattern normal? YES/NO Please explain:	List any health problems (Cancer, Diabetes, Heart disease, etc.) on father/mother's side of family or in siblings:

D) STRESSORS

Since problems that arise are related to many types of stressors and traumas, please fill in the following information as it is very important to us:

CHEMICAL	PSYCHOSOCIAL	TRAUMATIC
Was the baby breast-fed? YES/NO Duration:	Any difficulties with lactation, latching or sucking? YES/NO	Any traumas during pregnancy (falls, accidents)? YES/NO Please explain:
Food Intolerance? YES/NO Type:	Any behavioural problems? YES/NO Onset:	Any evidence of birth trauma: (E.g. bruises, odd shaped head, stuck in birth canal, fast or excessively long birth respiratory depression, cord around neck)
Any illness of the mother during pregnancy?	Any night terrors, sleep walking, difficulty sleeping? YES/NO Specify:	
Any supplements of mother during pregnancy?		
Any drugs taken during pregnancy?	Does your child seem normal for their age? YES/NO Please explain:	Any falls from couches, beds, change tables? YES/NO Please explain:
Any exposures to ultrasound? YES/NO If so, how many and what was the medical reason?		Any traumas with bruising, cuts, stitches, fractures? YES/NO Please explain:
Any Invasive procedures? (E.g. Amniocentesis, CVS)		Any hospitalizations? YES/NO Please explain:
Any smokers in the home? YES/NO		
Any vaccinations? YES/NO Which ones and any reactions:		Any surgeries or organs removed? YES/NO Please explain:
Any antibiotics? YES/NO Which ones and any reactions: Total number of courses of antibiotics:		Any history of ear infections, regular colds, strep throat, croup, pneumonia or bronchitis? YES/NO Please explain: