Your Child's Health History

Child's (legal) Name DOB (MM/DD/YY)

Parents'/Guardians' Names

Address/City Postal Code

Phone numbers (Home) (Cell)

Has your child been checked by a Doctor of Chiropractic? If yes, when did your child last see a chiropractor?

Purpose of this Visit

To help your child's body heal and grow physically, mentally and emotionally

A spinal check-up

To address a specific health concern (please explain):

When did this problem begin?

Is this problem Is this becoming worse?

Birth History

Did you have an ultrasound during this pregnancy? Place of Birth

Provider: Type of Birth

Were pain medications used? Type

Was labour induced? If Yes, why?

What position did you deliver in

Birth Trauma Doctor assisted Did your child have a misshaped skull/head?

Twisting and/or Pulling

Vacuum extraction

Forceps

Any newborn trauma? (Including medical procedures and tests)

Do you/did you breastfeed? If yes, for how long?

Does your child prefer one breast/side over the other? Side

Did your child have any negative reactions to a vaccination?

Is your child currently on medication? Medication Reason

Has your child ever had any surgeries? If Yes, please explain:

Baby/Toddler (0-3): have/did any of the following occur?

Fall from change table
Fall out of crib
Fall off playground equipment
Frequent ear infections
Frequent fevers
Other

Constipation
Repeated infections or colds
Inadequate weight gain
Tumble down stairs
Involved in MVA

Play in jolly jumper
Tonsillitis
Frequent bouts of diarrhea
Sleeping problems
Colic

Child (4-18): have/did any of the following occur?

Fall from a tree
Fall off of a bicycle
Car accident
Stomach pains
Scoliosis
Other

Bed wetting
Fall on playground
Hyperactivity/autism
Learning difficulties
Asthma
Backaches

Leg/knee pains
Sinus troubles
Neck problems
Headaches/dizziness
Recurrent ear infections
Sleeping problems/night terrors

How would you rate your child's diet?

Does your child consume artificial sweeteners?

Any known food or other allergies? (List)

Number of hours your child sleeps per day? Quality of sleep

Is/has your child been under therapy? Physio Nutritional Massage
Other

Is there anything else we should know about your child?

Authorization for Examination

I, the undersigning parent/person having legal custody/guardianship of

, a minor, do hereby request and direct Dr. Maya Pande and whomever she may designate as an assistant to perform in judgement any examination and chiropractic diagnosis which is deemed necessary.

Name of Child: **Date of Birth (MM/DD/YY):**

Parent/Legal Guardian Signature: ____

To be signed in the office.

Date (MM/DD/YY):

CANCELLATIONS AND MISSED APPOINTMENTS

A minimum of **4 HOURS NOTICE** is required to cancel an appointment, otherwise you will be charged a missed appointment fee of **$45.00.** This fee will **NOT** *be covered by any payment plans.*

I have read and agree to the above statements.

Patient/guardian's signature: ____

To be signed in the office.

Date (MM/DD/YY)