clinique chiropratique St-Joseph

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PEDIATRIC HEALTH PROFILE

Welcome to our clinic. Please complete this health questionnaire and let us know how we can work together at improving your family's health.

Patient's Name : _____

Address: _____City: _____ Postal Code:_____

Parent's Phone Number: _____ Work Phone Number: _____

Date of birth: _____ / _____ / _____ Gender:_____ Weight: _____ Height: _____

Parents Name: _____Referred by: _____

Main concerns about your child's health: _____

Are you referred by a health professional: YES or NO _____

Names of the health professionals and treatments received or recommended:_____

_____

Other health concerns? _____

What conditions has your child suffered from in the last six months:

____ Ear infection	____ Scoliosis	____ Convulsions	____ Fever
____ Asthma/Allergies	____ Digestive problems	____ Car Accident	____ Headaches
____ Colitis	____ Enuresis	____ Cold	____ Growing pain
____ Back Pain	____ Dyslexia	____ Hyperactivity	____ Attention Deficit Disorders

Others: _____

Hereditary history: _____

Chiropractor's Name:_____

Date of your last visit: _____ / _____ / _____ Reason:_____

Pediatrician's Name:_____

Date of your last visit: _____ / _____ / _____ Reason: _____

Number of antibiotic series prescribed to your child

During the last six months _____ Total: _____

Other medications prescribed to your child

During the last six months _____ Total: _____

Were you satisfied of your pediatrician's care? YES or NO _____

Vaccines: Which and when:_____

PRENATAL HISTORY

Gynecologist or mid-wife's name:_____

Complications during or after the pregnancy: YES or NO _____

If yes, which one: _____

_____

Number of ultra sounds during pregnancy: _____ Reason:_____

Medication during the pregnancy:_____ Reason:_____

Medication during delivery: _____ Reason: _____

Cigarette/alcohol during the pregnancy: YES or NO _____

Place of birth: Hospital: _____ Home: _____ Birth Center: _____

Intervention during the delivery: Forceps: _____ Suction cup:_____

Emergency C-Section: _____ Planned C-Section:_____ Epidural: _____

Complications during the delivery: YES or NO _____

Genetic Disorder: YES or NO _____

Weight at birth: _____ Length:_____ Tests APGAR: _____

FEEDING HISTORY

Breast fed: YES or NO _____ Number of month: _____

Milk Formula: YES or NO _____ Number of month: _____ Type: _____

Solid food at: _____ month

Allergies, food sensitivities: YES or NO _____

Parent's allergies, food sensitivities: YES or NO _____

DEVELOPMENT HISTORY

During infancy your child's nervous system and spinal column are vulnerable and should be verified regularly by a chiropractor. At what age did your child:

_____ Answer to noise
_____ Answer to touch
_____ Hold his head
_____ Sit
_____Crawl
_____ 4 legged crawl
_____Walk
_____ Stand

From National Security's statistics, 50% of children fall on their head from a considerable height (from bed, high chair, and stairs).

Was it the case with your child? YES or NO _____

Has your child ever practiced a contact sport (soccer, football, hockey, martial arts)? YES or NO _____

Which ones: _____

Was your child ever involved in a car accident? YES or NO _____

Has your child ever been to an emergency room? YES or NO _____

Reason:_____

Other traumas: (Separation, divorce, violence, death, moving, medical tests: _____
_____

Surgery :_____

INFANTILE DISEASE

Measles	yes / no _____ age: _____	Chicken Pox	yes / no_____ age: _____
German measles	yes / no_____ age: _____	Scarlet fever	yes / no_____ age: _____
Mumps	yes / no_____ age: _____	Whooping cough	yes / no_____ age: _____

AUTHORIZATION FOR CHILD'S HEALTH CARE

Signature required on site by a parent or tutor: _____