clinique chiropratique St-Joseph

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CHIROPRACTORS, D.C.

PEDIATRIC HISTORY

It is our pleasure to welcome you to our clinic.
To help us serve you better, please complete the following questionnaire.
Please tell us how we can work together to improve your health and the health of your family.

Last name : _____ Fist name : _____ Date (d/m/y) :_____/_____/_____

Address: _____ City: _____Postal code: _____

Parents home phone: _____ Work: _____

Parent's emails: _____

Date of birth: (day/month/year) : _____ / _____ /_____ Sex: _____ Weight: _____ Height:_____

Parent's name: Father_____ Mother: _____

Insurance company: _____ Policy number: _____

Would you like to receive your insurance receipts by e-mail___ or paper ___? Yes___ No___

How often would you like to receive them: weekly ___ monthly___ every 3 months___ every 6 months___

Who referred you to our office? _____

Reason for your visit: _____
_____

Other doctors consult for this condition: Yes____ No ____

Name of doctor and treatments received or recommendations: _____
_____

Your child has suffered or is suffering (check all conditions):

___ Ear infections
___ Recurrent fever
___ Digestive disorders
___ Psychomotor delay
___ Plagiocephalic
___ Growing Pain
___ Headache
___ Asthma/Allergies/Intolerances
___ Colic
___ Auto accident
___ Breastfeeding difficult
___ Back Pain
___ Convulsions
___ Repetitive colds
___ Enuresis (wet the bed)
___ Torticollis
___ Scoliosis

___ Reading Disorder
___ Hyperactivity
___ Coordination problem
___ Writing Disorder
___ Memory Disorder
___ Dyslexia
___ Concentration Disorder
___ Pronunciation Disorder

Other health issues: _____
_____

Family history: _____
_____

Name of chiropractor: _____

Date of last visit: (day/month/year) : _____ / _____ /_____ Reason: _____

Name of the pediatrician: _____

Date of last visit: (day/month/year) : _____ / _____ /_____ Reason: _____

Number of antibiotic treatments prescribed to your child
During the last six months: _____ In total during his or her life: _____
Number of medication prescriptions your child has received:
During the last six months:_____ In total during his or her life: _____
Were you satisfied with the care received from your pediatrician? Yes____ No _____

PRENATAL HISTORY

Name of gynecologist and/or midwife: _____
Complications of pregnancy: Yes____ No ____ If yes, which ones: _____
_____
Number of ultrasounds pending pregnancy: _____ Reason: _____
Medications during pregnancy: _____ Reason: _____
Medications during childbirth: _____ Reason: _____
Cigarette/alcohol during pregnancy: Yes _____ No ____
Birthplace: Hospital: _____ Home: _____ Birth center: _____
Medical Complications: Forceps: _____ Extraction Suction Cup: _____ Fetal distress: _____
Emergency cesarean: _____ or planned:_____ Epidural:_____
Complications during childbirth: Yes _____ No _____
Genetic disorder: Yes _____ No _____
Weight at birth: _____ Height: _____ APGAR Tests: _____

NUTRITION HISTORY

Breastmilk: Yes _____ No _____ How many months: _____
Formula: Yes _____ No _____ How many months: _____ Type: _____
Introduction to solids at: _____ months

Allergies, food intolerances: Yes _____ No _____
Allergies, food intolerances of parents: Yes _____ No _____

HISTORY OF DEVELOPMENT
It is during childhood that your child's spine and nervous system are the most vulnerable and should be checked regularly by a chiropractic doctor.

At what age did your child:

_____ Responded to sound
_____ Responded to manual stimuli
_____ Held his/her head
_____ Did he/she sit
_____ Crawl
_____ Walking on all fours
_____ Walked
_____ Did he/she stand up

According to the National Security Council, about 50% of children fall on their head of appreciable height (bed, high chair, changing table, staircase). Is this the case with your child?
Yes _____ No _____ Which ones: _____

Has your child been seen in the emergency room? Yes _____ No _____
Reason: _____

Emotional trauma (separation, divorce, violence, death, relocation, medical tests): _____
_____

Surgeries: _____

Child's name : _____ **Date of birth (d/m/y) :** _____/_____/_____

MOTOR DEVELOPMENT

1. Cerebellum

___ Impulsiveness poorly controlled, emotional peaks
___ Hyperactivity or passivity (oscillates between the 2)

2. RPP

___ Low stress tolerance
___ Shyness, difficulty to assert oneself
___ Sensory hypersensitivity to odors
___ Difficult eater
___ Love to be in the dark
___ Has trouble targeting an object in a group
___ Seeking intense sensations to the touch (barefoot, pungent, rough, tight clothes)
___ Insecurity
___ Anxiety
___ Insomnia / night terror / nightmare
___ Travel sickness
___ Do not like changes
___ Tensions in the muscles of the neck

3. MORO

___ Difficulty to get along with child of the same age, enter into conflict
___ Tends to dominate, controlling behavior
___ Hypersensitivity to touch ___ hearing ___ light
___ Like strange noises or make noise
___ Does not answer to name (functional hearing)
___ Do not like close contact (body care, brushing teeth, tight clothes, walking barefoot, hugs, etc.)
___ Appeal for all that is sweet
___ Bad night vision
___ Fear of the dark, worried
___ Low immunity (asthma, allergy)
___ Difficulty reading and / or writing

4. Babkin

___ Bringing objects to mouth
___ Mouth movements while writing / reading
___ Eats foods of a certain taste or texture
___ Has a strong preference for certain tastes or texture
___ Love to smell inedible objects

5. Babinski

___ Flat feet
___ Ankles lax, easily twisted
___ Walk on tiptoe
___ Do not like wearing shoes
___ Bad coordination
___ Toes stretch when thinking or working

6. RTAC

___ Lack of balance and / or coordination
___ Difficulty with precise fine motor skills
___ Difficulty attaching laces, buttons
___ Difficulty with scissors, fork
___ Difficulty for cross-activities (crawling)
___ Dominance right / left late
___ Difficulty holding the pencil, writing, spelling
___ Angles his paper, works sideways
___ Dyslexia

7. RTL Front

___ Difficult to hold head straight (often leans forward or sideways)
___ Vaulted posture
___ Hypermobile joints, very flexible
___ Difficulty climbing
___ Difficulty riding a bike
___ Difficulty swimming breaststroke
___ Lazy eye tendencies
___ Lack of balance when looking down (Does not like going down the stairs)

8. RTL Back

___ Lack of balance when looking up (Does not like going up the stairs)
___ Lack of orientation
___ Become anxious in a game in motion, if the feet do not touch the ground or head down
___ Adds movements during simple tasks

9. RTSC

___ Leans over his paper in writing
___ Prefer to sit on knees, indian style or legs in W
___ Wrap his/her legs around the chair legs
___ Visual difficulty far/near (difficulty to copy from the board)
___ Difficulty with ball games
___ Low hand-eye coordination
___ Low concentration, attention
___ Headache

10. Straightening of the head (vestibular)

___ Bad time management (late)
___ As soon as the eyes move, the head moves
___ Difficulty to find one's orientation (spaced out)

11. Galant

___ Hyperactive, restless, stirring
___ Do not like tight clothes
___ Enuresis (urge to urinate in bed)
___ Scoliosis. Bad short-term memory
___ Bad short-term memory

12. Landau

___ Lower body disorder, stumbles
___ Bad short-term memory
___ Difficulty jumping on one foot
___ Stiff, clumsy movements
___ Seems to have weak muscles
___ Pain in the back (cervical / thoracic / lumbar)

Child's name : _____ Date of birth (d/m/y) : _____/_____/_____

INFANT DISEASE

Measles Yes _____ No _____ Age: _____
Rubella Yes _____ No _____ Age: _____
Mumps Yes _____ No _____ Age: _____
Varicella Yes _____ No _____ Age: _____
Scarlet Fever Yes _____ No _____ Age: _____
Whooping Cough Yes _____ No _____ Age: _____

Vaccines received:

_____ When: _____
_____ When: _____
_____ When: _____
_____ When: _____

This information has been entered to the best of my knowledge.

Signature required by a parent or legal guardian:

_____

AUTHORIZATION OF CARE FOR A MINOR.

I hereby authorize the Chiropractor to carry out the exams that he deems necessary for the opening of my child's file. Some patients may experience stiffness or mild elevating symptoms after the exam. These symptoms are usually short lived and it is important to mention them to the chiropractor at the next appointment.

Child's name: _____ Date of birth (d/m/y) : _____/_____/_____

Signature required by a parent or legal guardian:

_____