

## PEDIATRIC HISTORY (4 pages)

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.

Date (d/m/y): \_\_\_\_/\_\_\_\_/\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth: (d/m/y): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Parent's name: Father \_\_\_\_\_ Mother: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Parent's emails: \_\_\_\_\_

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):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Ear infections       | <input type="checkbox"/> Headache                      | <input type="checkbox"/> Convulsions            |
| <input type="checkbox"/> Recurrent fever      | <input type="checkbox"/> Asthma/Allergies/Intolerances | <input type="checkbox"/> Repetitive colds       |
| <input type="checkbox"/> Digestive disorders  | <input type="checkbox"/> Colic                         | <input type="checkbox"/> Enuresis (wet the bed) |
| <input type="checkbox"/> Psychomotor delay    | <input type="checkbox"/> Auto accident                 | <input type="checkbox"/> Torticollis            |
| <input type="checkbox"/> Plagiocephalic       | <input type="checkbox"/> Breastfeeding difficult       | <input type="checkbox"/> Scoliosis              |
| <input type="checkbox"/> Growing Pain         | <input type="checkbox"/> Back Pain                     |   |
| <input type="checkbox"/> Reading Disorder     | <input type="checkbox"/> Writing Disorder              | <input type="checkbox"/> Concentration Disorder |
| <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> Memory Disorder               | <input type="checkbox"/> Pronunciation Disorder |
| <input type="checkbox"/> Coordination problem | <input type="checkbox"/> Dyslexia                      |   |

Other health issues: \_\_\_\_\_

Family history: \_\_\_\_\_

Name of chiropractor: \_\_\_\_\_

Date of last visit: (d/m/y) : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason: \_\_\_\_\_

Name of the pediatrician: \_\_\_\_\_

Date of last visit: (d/m/y) : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 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	_____ Crawl
_____ Responded to manual stimuli	_____ Walking on all fours
_____ Held his/her head	_____ Walked
_____ Did he/she sit	_____ 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
- \_\_\_ Hypermobility 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:**

\_\_\_\_\_