Harmonie
CHIROPRATIQUE

Health history

For children, newborn to 5 years

Child's Full Name: ____

D.O.B. ____________________ Age______________

Parent's full name and contact

Parent's name		
Address		
Phone number		
Email		

What concerns do you have regarding your child's health?

____

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Birth story

Was your child delivered:

- Naturally
- Breech
- C-section
- At term
- Induced
- Posterior
- Epidural
- Premature
- Waters broken
- Suction cups
- Forceps
- Late

Birth weight: _____________
Apgar score: _____________
Was your child's head misshapen at birth: Y/N

Duration of labor: ____________
Duration of pushing: _________

Were there any complications? _____________________________

Birth to 6 Months

Did your baby…

• Breastfeed?	How long?	• Have colic?	Mild/moderate/severe
• Formula feed?	What type?	• Have reflux?	Mild/moderate/severe
Have good quality of sleep?	Y / N	In which position did they sleep?	

Current history

Describe any injury your child incurred. (car accident, falls, surgery, emotional….)

List any current or past childhood illness.

List medication current or occasional.

Which of the following health practitioners has seen your child? When and why?

- Physiotherapist
- Nutritionist
- Chiropractor
- Paediatrician
- Naturopath
- Psychologist/Psychiatrist
- Occupational therapist
- Osteopath
- Other

I hereby authorize the chiropractor to conduct the exams necessary to open my child's file. I understand that some patients may feel a slight aggravation of symptoms following the examination. Although these symptoms generally don't last long, it is important to mention them to the chiropractor at the next visit.

Signature: ______________________ Date: ______________