Power On
FAMILY CHIROPRACTIC
Dr. Heidi F. Benda, BAA, DC
905 West 16th Street, North Vancouver, BC, V7P 1R2

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our family of happy and healthy chiropractic clients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

CLIENTS NAME:_____ HEALTH CARD # _____

ADDRESS: _____ CITY:_____

PROVINCE:_____ POSTAL CODE: _____ HOME # _____

BIRTHDATE: (M)_____(D)_____(Y)_____ WORK # _____

GENDER: _____ WEIGHT: _____ HEIGHT: _____

NAMES OF PARENTS/GUARDIANS: _____

PURPOSE FOR CONTACTING US? SPINAL CHECK-UP: _____ OTHER: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____Y _____ N

DOCTORS' NAMES & PRIOR TREATMENTS: _____

_____

OTHER HEALTH PROBLEMS: _____

PERTINENT FAMILY HISTORY: _____

HAS THIS CHILD BEEN UNDER PREVIOUS CHIROPRACTIC CARE: _____ Y _____ N

DATE OF LAST VISIT: _____/_____/_____

NAME OF PEDIATRICIAN: _____

DATE OF LAST VISIT: _____/_____/_____ REASON: _____

ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED? _____ Y _____ N

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS RECEIVED? _____ Y _____ N

DURING THE PAST 6 MONTHS: _____ TOTAL DURING HIS/HER LIFETIME: _____

NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAS TAKEN: _____

DURING THE PAST 6 MONTHS: _____ TOTAL DURING HIS/HER LIFETIME: _____

PRENATAL HISTORY:

NAME OF OBSTETRICIAN/MIDWIFE: _____

COMPLICATIONS DURING PREGNANCY: _____ Y _____ N, LIST: _____

ULTRASOUNDS DURING PREGNANCY: _____ Y _____N, NUMBER: _____

COMPLICATIONS DURING DELIVERY: _____ Y _____ N, LIST: _____

MEDICATIONS DURING PREGNANCY/DELIVERY: _____ Y _____ N, LIST: _____

LOCATION OF BIRTH: _____ HOSPITAL _____ BIRTHING CENTRE _____ HOME

BIRTH INTERVENTION: _____ FORCEPS _____ VACUUM EXTRACTION

_____ CESAREAN SECTION, EMERGENCY OR PLANNED: _____

APGAR SCORES _____ , _____ CIGARETTE/ALCOHOL USE DURING PREGNANCY: _____ Y _____ N

GENETIC DISORDERS OR DISABILITIES: _____ Y _____ N, LIST: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____

Power On
FAMILY CHIROPRACTIC
Dr. Heidi F. Benda, BAA, DC
905 West 16th Street, North Vancouver, BC, V7P 1R2

FEEDING HISTORY:

BREAST FED: _____ Y _____ N, HOW LONG: _____

FORMULA FED: _____ Y _____ N, HOW LONG: _____, TYPE: _____

INTRODUCED: SOLIDS AT _____ MONTHS, COW'S MILK AT _____ MONTHS

FOOD/JUICE ALLERGIES OR INTOLERANCES: _____ Y _____ N, LIST: _____

DEVELOPMENTAL HISTORY:

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN FALL FROM A HIGH PLACE DURING THE FIRST YEAR OF LIFE (i.e. A BED, CHANGING TABLE, DOWN STAIRS, ETC.). WAS THIS THE CASE WITH YOUR CHILD: _____ Y _____N

IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS (i.e. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.): _____ Y _____N

LIST:_____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT: _____ Y _____ N, LIST: _____

HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS: _____Y _____ N, LIST: _____

OTHER TRAUMAS NOT DESCRIBED ABOVE: _____ Y _____ N, LIST: _____

HOSPITALIZATION OR PRIORITY SURGERY: _____ Y _____ N, LIST: _____

CHILDHOOD DISEASES:

CHICKEN POX	Y / N AGE _____	MUMPS	Y / N AGE _____
RUBELLA	Y / N AGE _____	WHOOPING COUGH	Y / N AGE _____
RUBEOLA	Y / N AGE _____	OTHER	Y / N AGE _____

DOES YOUR CHILD OR HIS/HER SIBLINGS SUFFER FROM:

ASTHMA	Y / N AGE _____	SKIN PROBLEMS	Y / N AGE _____
ALLERGIES	Y / N AGE _____	DIFFICULTY SLEEPING	Y / N AGE _____
HYPERACTIVITY	Y / N AGE _____	COLIC	Y / N AGE _____
BED WETTING	Y / N AGE _____	DIGESTIVE DIFFICULTIES	Y / N AGE _____
EAR INFECTIONS	Y / N AGE _____	(CONSTIPATION, DIARRHEA)	

AUTHORIZATION FOR CARE OF MINOR:

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

I have read the above statements and consent to treatment.

Signature _____ Date Signed _____

Power On
FAMILY CHIROPRACTIC
Dr. Heidi F. Benda, BAA, DC
905 West 16th Street, North Vancouver, BC, V7P 1R2

Date: _____

Name: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

Numbness /////

Pins & Needles ••••

Burning XXXXX

Dull & aching +++++

Stabbing & sharp *******

Stiff & tight 222222