# Newborn or Child's Health History

Today's Date: _____ Birth Date: _____

Last Name: _____ First Name: _____

Parent/Guardian Names: _____

Address: _____ City _____ P.C. _____

Home Phone: _____ Parent Cell: _____ Work: _____

Care Card Number: _____ Family Physician: _____

Email address (for appointment reminders) _____

Who may we thank for referring you to our office? _____

Primary reasons for consulting our office? _____

Has your child had previous Chiropractic care? ❑ Yes ❑ No Dr.'s Name: _____

What other wellness professionals are currently a part of your health care team?

❑ Massage Therapist ❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Other _____

How many Medical Doctor's visits in the past year? ❑ None ❑ Less than 5 ❑ More than 5 ❑ More than 10

List previous surgeries and dates: _____

Medications (prescription and over-the-counter): _____

**Health History:**

| | | |
|---|---|---|
| ❑ Illness during Pregnancy | ❑ Labour induced | ❑ Pulling or twisting during delivery |
| ❑ Forceps/ C-Section/Vacuum | ❑ Premature delivery | ❑ Vaccinations |
| ❑ Colic | ❑ Sleeping problems | ❑ Eating or nursing problems |
| ❑ Falls in first year of life | ❑ Other falls or injuries | ❑ Respiratory problems |
| ❑ Ear infections | ❑ Allergies/Asthma | ❑ Digestive problems |
| ❑ Hyperactivity | ❑ Sports Injury | ❑ Auto accident or injury |
| ❑ Family/Home stress | ❑ Ever Hospitalized | ❑ Major Illness |
| ❑ Reoccurring Illnesses | ❑ Limited Exercise | ❑ Emotional traumas |

Any other health related problems? _____

_____

I hereby authorize Dr. Holdsworth and whoever may be designated as assistants to provide Chiropractic care as may be deemed necessary to my child/ward.

Signed: _____ (parent/guardian)