

Welcome to **Wellroots.ca**

When you have completed this page please hand it into the reception desk.

Vital Information (Child)

Child's First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Business Phone _____ ext _____

Mobile Phone _____

Email address _____

Date of Birth: D ___ /M ____ /Y _____

Name(s) of Parent(s) _____

Other children? No Yes - Names (ages): _____

Name of additional caretaker(s) _____

Emergency contact _____ Phone _____

Has your family seen a chiropractor before? No Yes – If so, when? _____

Reason for seeking services at **Wellroots.ca**: _____

How did you find out about **Wellroots.ca**? _____

Is there anything about your child's nerve system and spine we should know about? _____

What is your level of commitment to you and your child's life and well-being?

High

Medium

Low

Additional Comments: _____

Vital Information (Child, Continued...)

Thank you for completing this more detailed questionnaire. All the information we collect is confidential and is valuable in order for us to provide you with exceptional service. If you have any questions please ask the host or the Chiropractor. Please inform the host or the Chiropractor when you have completed this information.

First Name _____ Last Name _____

Name of previous chiropractor and date of last visit? _____

Describe Experience _____

Name of present MD/Pediatrician and address? _____

Date and reason for last MD visit? _____

Does your child have any current health concerns? If yes, please describe and complete the following questions, if no move onto * _____

When did this/these health concern(s) begin? _____

Have you sought advice or treatment from a health professional? Yes No

If yes, what were you told? _____

What was done? _____ Did it seem to work? Yes No

Please indicate how this condition affects your child's daily function and the function of your family? _____

What concerns you about this situation? _____

Why do you think your child is experiencing this health event? _____

*What are your expectations of your chiropractic care at **Wellroots.ca**? _____

To develop an understanding about Chiropractic, the body's healing ability, life force and the nervous system we request that you attend one of our special Wellness Lectures during your first month of your child's care. Are you interested in attending one of our seminars?

Yes No Will consider

Family and Personal History:

Please list whether you or anyone in your close family has a history of any of the following:

Cancer _____

Diabetes _____

Heart disease/high blood pressure _____

High cholesterol _____

Any other health concerns _____

History of pregnancy, labour and birth:

Pregnancy

Name of Obstetrician/Midwife _____

Please list any medical or alternative, treatments or procedures done during pregnancy _____

Please list any drugs, herbs or supplements taken during pregnancy _____

Please list any traumas to the mother during pregnancy (e.g. accidents, emotional) _____

Labour & Birth

Birth attendants (MD, Midwife, Doula) _____

Location of Birth _____

Mother's position during labour (back side, sitting standing, other) _____

Was labour induced? Yes No

Did the mother receive any drugs before during or after the birth process? (Epidural, Morphine, Other) _____

Was an episiotomy performed? Yes No

Duration of labour _____

Duration of delivery (time spent in birth canal) _____

Birth Position? Cephalic (head first) Occiput Posterior (facing forward)
 Breech (feet first) Other _____

Any assistance required during birth? (e.g. forceps, vacuum extraction, manual assistance, Cesarean) _____

Any complications during or after birth? (e.g. stuck in birth canal, cord around neck) _____

Any evidence of trauma during birth (e.g. bruises, marks) _____

Was your child subjected to any procedures following birth?

Silver Nitrate eye drops Incubation (how long?) _____

Vitamin K injection Separation from mother (how long?) _____

Respiration Other _____

Was your child alert and responsive within 12 hours of delivery? Explain _____

What was the child's gestational age at birth? _____ weeks

Birth Weight _____ Birth Length _____

Congenital Anomalies or defects present? _____

Growth and Development:

At what age did your child:

Follow an object _____ Respond to Sound _____

Hold up head _____ Sit unassisted _____

Vocalize _____ Talk _____

Teethe _____ Crawl _____

Walk _____ Run _____

PHYSICAL STRESSORS, activities, habits, traumas or challenges:

Please list the details, treatments and age/date (as necessary) of past and present PHYSICAL experiences:

Surgeries/Hospitalizations _____

Falls (e.g. from couches, beds, change table) and accidents _____

Traumas resulting in bruises, fractures or stitches _____

Car Accidents (describe) _____

Other Past or Current Illness/Infection _____

How much (and what kind of) exercise does your child get? _____

Is a school backpack used? No Yes (Heavy) Yes (Light)

Other _____

CHEMICAL STRESSORS, activities, habits, traumas or challenges:

Please indicate present and past exposures during pregnancy to (per day/week):

Cigarette Smoke _____

Alcohol/Caffeine _____

Supplements: _____

Medications/procedures (e.g. amniocentesis, ultrasound) _____

Was your child breastfed? No Yes (until what age?) _____

Introduced to formula? No Yes (at what age?) _____

Introduced to cows milk? No Yes (at what age?) _____

Solid foods at what age? _____

Please list your child's history of antibiotic use and types _____

Please list your child's history of vaccinations and the age given _____

Reason for vaccinations? _____

Any adverse reactions? _____

Any smokers in the home? _____

Any pets in the home? _____

What are your child's typical daily food choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What is your child's daily fluid intake? How many glasses of:

Water _____ Juice _____ Pop _____ Dairy _____

Other _____

EMOTIONAL/MENTAL STRESSORS activities, habits, traumas or challenges:

Any problems with lactation and/or feeding? _____

Any problems with bonding with your child? _____

Any behavioural problems? _____

Any emotional traumas? (e.g. death in family, abuse, school) _____

Does your child sleep through the night? Yes No Sleeping Position? _____

How many hours does your child sleep a night? _____ Quality? _____

Any night terrors, sleep walking, bedwetting or difficulty sleeping? _____

How many hours per week does your child watch television? _____

Approximate hours of playtime per week _____

Do you feel that your child's physical, social and emotional development is normal for their age? (Please explain) _____