TOTAL BODY HEALTH

PEDIATRIC HEALTH HISTORY FORM

Welcome and Thank you for trusting us with your child!

Name: ________________________________ Date: ____________________

Birthday (M/D/Y): ____________________ MSP #: ________________________

Parents/Guardian Names: ____

Address: ____

Email: ____________________________________ Join our Newsletter: Yes or No

Phone # : __________________________ Other # _______________________

How did you hear about us: ____

HEALTH STATUS

Purpose of this appointment: ____

____

What do you feel is the cause of your child's problem?________________________

____

When did you first notice this sign of body dysfunction? _____________________

____

Is this dysfunction getting progressively worse? ___Yes ___No
If yes, why do you think so?

____

What are the most significant measures you have taken to date to improve your child's present health challenge? Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

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Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly (trauma, emotional distress etc.)

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HISTORY OF CHILD'S BIRTH

Birth weight: ______________________ Birth Length: ____________________

Type of Birth: ☐ Vaginal ☐ Caesaren ☐ Forceps ☐ Breech ☐ Vacuum
☐ Home ☐ Hospital

☐ Midwife ☐ Family Physician: Name: ______________________________________

Length of delivery: ____

Any Complications during Delivery: ___________________________________

At birth was there jaundine or cyanosis (blue colour)? _____________________

Do you remember the APGAR score at birth? (score is out of 10) _______________

Any congenital anomalies or birth defects? ___________________________________

INFANT FEEDING

Was your child breast-fed? ___Yes ___ No If yes, for how long? ______________

How was latching at birth: ____

Was your child formula fed? ___Yes ___No If yes, what type and for how long?
____

At what age did you introduce solid foods into your child's diet? _______________
What type(s)? ____

Has your child exhibited any tolerance and/or allergy to any specific food? ___Yes ___No
If yes, please list all foods.____
____

Has your child been tested for allergies? ___Yes ___No
If yes, how were the tests performed______________________________________
Results? ____
If so how does it present itself? (Skin rash, hives, digestion / respiratory issues)
____
____

QUALITY OF SYSTEMS

Quality of sleep: ____

Quality of Bowel movements: ____

Immunization history: ____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

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Please check **ALL** that apply:

____ Allergies	____Freq. colds/ congestion	____Upper respiratory Infections	____Asthma
____Ear infections	____Infected/ sore Throat	____Tonsillitis	____Laryngitis
____Colic	____Reflux/spit-ups	____U-tract infections	____Poor appetite
____Poor digestion/ (constipation/diarrhea)	____Thrush mouth/Chronic diaper rash	____Eczema/psoriasis/ Other skin rashes	____ADD/ADHD
____Irregular sleep Patterns	____Night terrors	____Bed wetting / Freq Urination	____Headache
____Anxiety	____Mood swings	____Bruising	____ Epilepsy/ Seizures
_____ Pneumonia	_____ Whooping cough	____ Chicken pox	____ Arthritis
____ Scoliosis	_____ Behavior problems	____ Anger /Violent	____ Trouble focusing

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

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____

Has your child taken Acetaminophen or Ibuprofen or any other products that contain these chemicals? ____ Yes ____No
If yes, for what reason and for how long? ______________________________

Has your child ever been hospitalized? ____ Yes ____No
If yes, why and when? (Please list in chronological order, include all surgeries) ____________
____

Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them. (Major falls, broken bones, concussion etc..)

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Please check any of the following sports activities that your child is engaged in.

____ Football	____ Lacrosse	____ Soccer	____Track/Field
____ Bowling	____ Tennis	____ Hockey	____ Volleyball
____Baseball/Softball	____ Skateboarding	____Snowboarding	____ Skiing
____Gymnastic/Trampoline	____BMX/Motorcross	____ Swimming	____Golfing
_____ Skating	_____ Horse riding	_____ Rowing	____ Dance

Has your child ever been injured while playing sports? ____ Yes ____No
If yes, what type of injury(s) occurred?

____

____

FOOD INTAKE

Recent research reveals that 31% of Canadian children are obese.
On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

__1 __2 __3 __4 __5	**__1 __2 __3 __4 __5**	**__1 __2 __3 __4 __5**	**__1 __2 __3 __4 __5**
Non-Complex Carbohydrates **_Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy**	**Complex Carbohydrates** Fruits & Vegetables	**Protein** Nuts, Seeds, Meats, Eggs	**Fats** Dairy Products

Please list the (3) most common foods eaten by your child each day.

____

How many times per month does your child eat fast food? _______________
What type? ____

What is the primary beverage consumed by your child? ______________________________

How much water does your child drink each day? ___________________________________

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? __________