School Age Case History (Ages 6 - 16 Years)

Please complete the following in as much detail as possible. Your answers will allow us to determine how best to care for your child.

Personal Information

Last Name: _____ First Name: _____

Parents'/Guardians' Names: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Other Phone: _____ Age: _____ Birthdate: _____

E-mail address: _____

Medical Doctor: _____ Pediatrician: _____

Medical Services Plan (Care Card) Number: _____

What are your child's primary health challenges? _____

_____

What are your goals once these challenges have been addressed? _____

_____

Which other health professionals have you consulted regarding your child's health challenges?

_____

Who may we thank for you referral to our office?

_____

Prenatal History

Complications during pregnancy: _____

Did you carry your child to full term? □ Yes □ No (If no, how early did you deliver? _____)

Did you use any medications or drugs during your pregnancy? □ Yes □ No

Labour and Delivery History

Was your labour:		□ Spontaneous	□ Induced
Was your labour unusually long?		□ Yes	□ No
Was your pushing phase unusually long?		□ Yes	□ No
Were any medications used during your labour?		□ Yes	□ No
Interventions used during your labour?	□ Forceps	□ Suction	□ Heavy Manual Traction
If you had a C-section, was it:	□ Emergency		□ Non-Emergency

Health History

In the past six months, has your child experienced:

□ Allergies _____
□ Back or Neck Pain
□ Bedwetting
□ Bowel Difficulties
□ Colds (more than normal)
□ Ear infections
□ Digestive Issues
□ Food Sensitivities _____
□ Vaccine Reactions
□ Sleep Difficulties
□ Headaches
□ Menstrual Difficulties

Developmental History

Have any learning or behavioral challenges been identified? □ Yes □ No

If yes, please describe: _____

Have there been any issues with concentration, distractibility, or ability to complete tasks? □ Yes □ No

If yes, please describe: _____

Activity History

How long does your child spend working at the computer and studying each day?

□ 1 Hour or less □ 1-2 Hours □ 2 Hours or more

Have there been issues with excessive computer gaming or computer time? □ Yes □ No

How much time does your child spend watching TV each day?

□ 1 Hour or less □ 1-2 Hours □ 2 Hours or more

How much time does your child spend being active each day?

□ 1 Hour or less □ 1-2 Hours □ 2 Hours or more

In which sports/activities is your child involved? _____

Trauma History

Has your child ever:

□ Fallen from a height
□ Fallen from a moving object
□ Fallen down the stairs
□ Been in a motor vehicle accident
□ Been the victim of physical/sexual abuse
□ Broken any bones

□ Experienced any other trauma _____

Is there anything else you would like us to know about your child?_____

_____

_____

Health Information:

What are your objectives in seeking chiropractic care? (please check all that apply)

☐ Relief of symptoms
☐ Decrease the risk of symptoms returning
☐ Improve spinal stability
☐ Decrease risk of re-injury
☐ Improve sleep regulation
☐ Improve overall health and well being
☐ Improve emotional regulation
☐ Other (please list) _____