Pure-Health
CHIROPRACTIC CENTRE

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Dr. Laina Shulman
Dr. Jamie Neely

Date:_____

Child's Name: _____Parent's Name_____

Is this a wellness care visit? Yes/No

If no…What is the chief health concern?

_____

When did it first begin?_____

How often is it of concern?_____

What makes it better? _____

What makes it worse? _____

Effects of problems on body function and daily activities:

_____

Other health concerns:_____

_____

History of birth:

Hospital ☐ Birthing Centre ☐ Home ☐ Medical ☐ Midwife ☐

Duration of pregnancy_____weeks

Was the baby breech Yes ☐ No ☐

Interventions delivered to mother at birth? (i.e. forceps, vacuum, c-section) No ☐ Yes ☐

If yes, what were they?_____

Duration of labour/birth

_____

Complications at birth Yes ☐ No ☐ If yes explain

_____

Birth weight _____ Birth length _____

Growth and Development

Was the infant alert and responsive within twelve hours of delivery? Yes □ No □
If no explain
_____

Did the child reach all his/her milestones at an appropriate age? (i.e. hold up head, sit, walk…)
Yes □ No □

If no, explain_____

Do sleeping patterns seem normal to you? Yes □ No □
If no,
explain_____

Any health problems (cancer, diabetes, heart disease, etc) on

the mother's side of the family_____On the father's side_____
siblings_____

Since problems that chiropractors concern themselves with can be related to many types of stresses the following information is also very important to us:

Chemical Stresses:

Was this baby breast-fed? Yes □ No □ how long_____

Formula introduced at age_____ type of formula used _____

introduction of cow's milk at age _____

Began solid foods at age _____ type_____

Food/juice intolerance No □ Yes □ Please provide details below:

_____

During pregnancy did mother:

Smoke □ drink alcohol □ have illness □ take supplements □ any other drugs □

ultrasounds □ invasive procedures □

Any pets at home Yes □ No □

Any smokers in the house No □ Yes □ how many_____

Any vaccinations Yes □ No □

If yes, were there any visible reactions?_____

Any antibiotics Yes □ No □

if yes, which ones_____how often_____

For what illness _____

Does your child take any other type of medication? yes/no

If yes, please explain_____

Psychosocial stresses

Any difficulties with

Lactation □ bonding □ behavioral □ night terrors □ sleepwalking □ difficulty sleeping □

Is your child in daycare Yes □ No □

Traumatic stresses

Any traumas during pregnancy (falls accidents) Yes □ No □

Any evidence of birth trauma

bruises □ odd shaped head □ stuck in birth canal □ fast birth □ excessively long birth □ respiratory depression □ cord around neck □ other _____

Any falls from Change table □ couches □ beds □

Any traumas bruising □ stitches □ fractures □

Any hospitalizations No □ Yes □

If yes, explain_____

Any surgeries or organs removes Yes □ No □

Sports played and age began_____

Any additional information you feel would be valuable

_____

_____