HARBOURFRONT FAMILY Chiropractic
DR. WARREN GAGE D.C., F.I.C.P.A.

Child Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
Age:	DOB:	Sex: ◯ M ◯ F
Street Address:		Height:
City / Prov/ Postal Code		Birth Weight:
Email:	Home Phone:	Cell Phone:
Mother's Name:	Father's Name:	
Who is your child's primary care physician?		
BC Care Card #	HFC ID #	
How did you hear about us?		

MOTHER'S HISTORY DURING PREGNANCY

Duration of gestation (in weeks):

Did you take medication/recreational drugs during pregnancy? ◯ YES ◯ NO If so, which ones?

Did you smoke during pregnancy? ◯ YES ◯ NO

List any supplements taken during pregnancy:

Any illness during pregnancy?

Any exposure to ultra-sound? ◯ YES ◯ NO If yes, how many and why?

BIRTH TRAUMA

Birth trauma and spinal subluxations have a significant impact on a child's health and well-being. Please answer the following important questions to the best of your ability, in as much detail as is practical.

Where was your child born? ◯ HOSPITAL ◯ BIRTHING CENTRE ◯ HOME

Did you use? ◯ MIDWIFE ◯ DOULA ◯ OBSTETRICIAN ◯ GP

Did you have a C-Section? ◯ YES ◯ NO

Were forceps used? ◯ YES ◯ NO

Were you induced? ◯ YES ◯ NO

Did you have an epidural? ◯ YES ◯ NO

Was it a difficult birth? ◯ YES ◯ NO

Was the baby's skull/head mis-shapen? ◯ YES ◯ NO

Were there purple marking on the baby's face? ◯ YES ◯ NO

Did you have complications during delivery? ◯ YES ◯ NO

If so, please describe:

EARLY CHILDHOOD HISTORY

Has your child been under chiropractic care? ◯ YES ◯ NO If so, when (date):

Was your child adopted? ◯ YES ◯ NO

Was your child breastfed? ◯ YES ◯ NO If so, for how long? Any difficulties breastfeeding? ◯ YES ◯ NO

Any difficulties with bonding? ◯ YES ◯ NO

Any behavourial problems? ◯ YES ◯ NO

Any night terrors, sleepwalking or difficulty sleeping? ◯ YES ◯ NO

Does your child seem normal for their age? ◯ YES ◯ NO

If no, please explain:

If your child has a specific condition or symptom please explain:

List prescription or over-the-counter medications taken currently:

Number of doses of antibiotics your child has taken during their lifetime:

Number of doses of other prescription medications including antibiotics your child has taken during their lifetime:

List reasons for your child taking prescription medication:

Does your child experience any of the following (please indicate all that apply):

◯ Headaches ◯ Postural Imbalance ◯ Scoliosis ◯ Sinus Problems
◯ Allergies ◯ Ear Infection ◯ Seizures ◯ Bedwetting
◯ ADD/ADHD ◯ PDD/Autism ◯ Frequent Colds ◯ Learning Disabilities
◯ Growing/Back Pains ◯ Digestive Problems ◯ Colic ◯ Asthma

List your child's allergies:

VACCINATION HISTORY

Has your child received any vaccinations? ◯ YES ◯ NO

Were there any reactions to the vaccinations? ◯ YES ◯ NO If yes, please describe:

TRAUMAS & ACCIDENTS

As a baby/toddler/young child did any of the following occur (please indicate all that apply):

◯ Falls from change table ◯ Fall off a bicycle ◯ Car Accident ◯ Fall from a tree
◯ Fall out of a crib ◯ Play in "jollyjumper" ◯ Tumble down stairs ◯ Sports Accident
◯ Other ◯ Fall from playground equipment

Has your child been involved in contact sports? ◯ YES ◯ NO

Has your child been taken to an emergency room? ◯ YES ◯ NO If so, why?

Describe any hospital stays or surgery:

Is there anything else you feel we should know?