

# Vital Information (Child)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Parent(s) Names: \_\_\_\_\_

Siblings Names and Ages: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Parents email address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: /M\_\_\_\_ /D\_\_\_\_/Y\_\_\_\_

Reason for seeking services at the Café of Life?  
\_\_\_\_\_  
\_\_\_\_\_

Who may we thank for referring you to the Café of Life?  
\_\_\_\_\_

Has your child ever seen a Chiropractor? If yes, who? Date of last visit?  
\_\_\_\_\_  
\_\_\_\_\_

## **PREGNANCY:**

Trauma/ illness during pregnancy: \_\_\_\_\_

During pregnancy did mother Smoke? Yes No  
How much? \_\_\_\_\_

Drink? Yes No How much? \_\_\_\_\_



Birth Assistants? Midwife  Doula  Medical Doctor

Any assistance needed during birth? Forceps  Vacuum extraction   
Cesarean

Any complications during birth? Yes  No  Please explain:

\_\_\_\_\_

Was the Child delivered before, on, or after the due date (how long)?

\_\_\_\_\_

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_

Any evidence of birth trauma to the infant? Check all that apply:

Bruising  Odd shaped head

Stuck in birth canal  Fast or excessively long birth

Respiratory depression  Cord around neck

Was your child subjected to any of the following? Check all that apply:

Silver nitrate drops in eyes  Incubation How long: \_\_\_\_\_

Vitamin K shot  Separation from you How long:

\_\_\_\_\_

Hepatitis shot  Meconium in the Embryonic Fluid

Was infant alert and responsive within 12 hours of delivery? Yes No

If no, explain: \_\_\_\_\_

Congenital anomalies/ defects present? \_\_\_\_\_

### **VACCINATION HISTORY:**

What vaccinations and age given? \_\_\_\_\_

\_\_\_\_\_

Any negative reactions? Yes No \_\_\_\_\_

Reason for vaccinations? \_\_\_\_\_

**GROWTH AND DEVELOPMENT:**

Any falls from couches, beds, change tables? Yes No  
\_\_\_\_\_

Any traumas resulting in bruises, fractures, stitches? Yes No  
\_\_\_\_\_

Any hospitalizations or surgeries? Yes No  
\_\_\_\_\_

History of antibiotics? Yes No  
\_\_\_\_\_

Do you consider sleeping pattern normal? Yes No  
\_\_\_\_\_

Number of hours of sleep? \_\_\_\_\_ Quality? Good ڤ Fair ڤ Poor ڤ

Night terrors, sleep walking, difficulty sleeping? Yes No  
\_\_\_\_\_

Was child breast fed? Yes No How long?  
\_\_\_\_\_

Difficulties with lactation Yes No  
\_\_\_\_\_

Formula introduced at what age? \_\_\_\_\_ What Formula?  
\_\_\_\_\_

Introduction of cows milk at what age? \_\_\_\_\_

Solid foods at what age? \_\_\_\_\_ Type of food? \_\_\_\_\_

Food/juice intolerance? \_\_\_\_\_

Problems with bonding? Yes No \_\_\_\_\_

Behavior problems? Yes No \_\_\_\_\_

Age of child when began daycare? \_\_\_\_\_

Do you feel that you r child's social and emotional development is normal for theirage?

Cont.

Yes No \_\_\_\_\_

Any sports played? Yes No \_\_\_\_\_

Is school backpack used? Yes No Heavy ثق  
Light خفيف

### **AUTHORIZATION FOR CARE OF A MINOR (Under Age 16)**

Print Parent Name \_\_\_\_\_

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed Signature \_\_\_\_\_

Name of Obstetrician / Midwife: \_\_\_\_\_

Name of Pediatrician/ Family MD: \_\_\_\_\_

Date of last visit to MD: \_\_\_\_\_ Purpose of visit: \_\_\_\_\_