



# 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

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