Child's Personal Information

Name_____ Date _____

Address_____ City _____ Province _____

Postal Code _____ Date of Birth: D____M____Y_____ Age _____

Parent: _____ Parent: _____

Home Phone _____ Cell Phone _____ Email _____

Where do you prefer to be contacted? Home ____ Work ____ Cell ____

Whom may we thank for referring your child to The Lifehouse? _____

We highly recommend subscribing to our email list to receive our monthly newsletter plus information about events and promotions. Would you like to be added to our list ☐ Y ☐ N

Check the phrase that most represents your child's reason for care:

0 Wellness 0 Prevention 0 Feel Good 0 Symptom Relief

Health Concerns *(If there are no current concerns and this assessment is to ensure optimum health and functioning, skip to the next page)*

Concern	Severity 1= Mild 10= Worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is the symptom present?

Is this condition interfering with your child's:

0 School 0 Behaviour 0 Sleep 0 Daily Routine 0 Sports/Activities

Other: _____

Is there a family history of similar concerns? 0 Yes 0 No

Please Explain _____

What other health practitioners has your child seen? (Mark P for past or C for current)

0 Chiropractor 0 Medical Doctor 0 Naturopath 0 Physiotherapist 0 Massage Therapist

Other _____

What have you done for this condition? Was it of benefit? _____

Often seemingly unrelated symptoms can tell us information about the function of

the nervous system and overall health:

(Please check if your child has had any of the following – past or present)

__ headaches
__ dizziness
__ fainting
__ fatigue
__ irritability
__ anxiety
__ poor concentration
__ poor coordination
__ seizures
__ weight loss/ gain
__ vision changes
__ heart palpitations
__ shortness of breath
__ asthma
__ allergies
__ eczema
__ urinary problems
__ constipation
__ diarrhea
__ bloating/gas
__ frequent colds
__ sore throats
__ ear pain/ infections
__ sinus congestion
__ neck pain
__ upper back pain
__ low back pain
__ pain in other joints
__ reduced mobility
__ numbness in leg(s)/feet
__ numbness in arms/ hand(s)
__ muscle cramps
__ 'growing pains'
__ sleeping problems
__ learning challenges

Other: _____

Physical Health

Please list any childhood falls/accidents

Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N
Type: _____ age: _____ Hospitalized? Y N

Please list if your child has had any surgeries:

Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____

Pregnancy History

Any traumas / illnesses? 0 Yes 0 No _____

Did the mother:

Smoke? 0 Yes 0 No Drink Alcohol? 0 Yes 0 No
Take Medication? 0 Yes 0 No

Labour History Please check all that apply:

0 Drug induction 0 Epidural 0 Antibiotics during labour

Duration of labour: _____ Duration of pushing phase: _____

Was there any assistance used?

0 forceps 0 vacuum/suction 0 manual traction from caregiver 0 c-section

Were there any complications during birth? 0 Yes 0 No
Please explain: _____

Infant Health Please check all that apply:

Was there any evidence of trauma following birth?
0 bruising 0 odd shaped head 0 stuck in birth canal 0 respiratory distress
0 excessively fast birth 0 prolonged labour

Did your child experience any of the following:
0 Incubation How long? _____
0 Separation after birth? How long? _____
0 Colic
0 Digestive
0 Nursing difficulties
Other: _____

Was your child breastfed? 0 Yes 0 No For how long? _____

Sports and Activities

Any sports? _____ How often? _____

Does your child carry a backpack? 0 Yes 0 No 0 Heavy 0 Light

Hours per week watching TV? 0-10 10-20 20-30 30-40

Hours per week on computer? 0-10 10-20 20-30 30-40

Biochemical History

Please list ALL drugs your child currently takes or has taken in the past 6 months:
Name:_____ Reason:_____ Prescribed? Y N
Name:_____ Reason: _____Prescribed? Y N
Name: _____Reason: _____Prescribed? Y N

Has your child taken antibiotics? Y N If yes, how many times? _____

Please list all nutritional vitamins or homeopathic remedies your child currently takes:
Name:_____ Reason:_____ Prescribed? Y N
Name:_____ Reason: _____Prescribed? Y N
Name: _____Reason: _____Prescribed? Y N

Has your child been vaccinated? Y N Age of first vaccination: _____

If so, has he/she had a reaction to vaccination? Y N
If so, please explain: _____

Nutritional Choices

Please grade any dietary selection that is appropriate for your child using the following scale:

FD – consumed a few times per day
FW – consumed a few times per week
FM – consumed a few times per month
M – consumed monthly
D – consumed once per day
W – consumed once a week
O – does not consume this

____ Fruits
____ Vegetables
____ Protein
____ Breads, pastas
____ Dairy (milk products)
____ Refined sugar
____ Artificial sweeteners
____ Soft Drinks
____ Processed food

Do you have any dietary concerns for your child? 0 Yes 0 No
If so, please explain:_____
_____

Emotional/ Developmental History

Have there been any significant family stresses since your child's birth? 0 Yes 0 No
If so, please explain (include age of child at the time) :
_____
_____

Age child began daycare/alternative caregiver: _____ Please circle: Part time / Full time

Have developmental milestones been met? 0 Yes 0 No _____

At what age did your child:

Sit unsupported: _____ Crawl: _____ Stand: _____
Walk: _____ Talk: _____

Do you have any concerns regarding your child's development? 0 Yes 0 No
If so, please explain:
_____
_____

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