Spinal Vitality Holistic Center
Holistic Family Care · Wellness Education
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CHILD HEALTH HISTORY

Name		Date	
Gender	☐ Male ☐ Female	DOB	Age
Address			
Address		Phone	
Mothers Name			Age
Education Level Attained			
Fathers Name			Age
Education Level Attained			
Legal Guardian			
Person completing form			

Family History

Family history can often be helpful in understanding a child's issues.

Has anyone in the family had:	Siblings	Parents	Extended Family
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, Depression or other psychological problems			
Seizures/Epilepsy			
Attention problems/Hyperactivity			

Please list all family members (in or out of house) and others currently in the house

Name	**Relationship**	**Age**	**Currently in the house?**

Parents are: ☐ Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed

Birth History

How would you describe your pregnancy?_____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, High blood-pressure, etc?_____

Did you receive any vaccinations while pregnant? ☐ Yes ☐ No

Was there any dental work done while pregnant? ☐ Yes ☐ No
If yes, what:_____

Did any very stressful situations occur during pregnancy? ☐ Yes ☐ No

Please check what best describes your labor and birth of your child?

☐ Normal	☐ Rh Factor problems	☐ Caesarian section
☐ Mother was sick	☐ Long/difficult labor	☐ Forceps or suction used
☐ Complications during birth	☐ Epidural	☐ Induced
☐ Problems with the umbilical cord	☐ Facial/Breech/Brow presentation	

Did your child have any of the following problems at birth:

☐ Difficult breathing	☐ Heart problems	☐ Infection
☐ Low birth weight	☐ Problems with bones/joints	☐ Jaundice
☐ Fever or Seizures	☐ Required blood transfusion	☐ Intensive care
☐ Bruised anywhere	☐ Nerve Problems	

Does /did your child have any birth defect? ☐ Yes ☐ No
If yes, list:_____

Describe what your child's temperament was like as an infant.

☐ Difficult	☐ Calm	☐ Sleepy	☐ Hyper sensitive
☐ Irritable	☐ Active	☐ Easily scared	☐ Frequent crying
☐ Sociable	☐ Cranky	☐ Happy	☐ Alert
☐ Other:_____			

During the first twelve months, was your child:

Difficult to get to sleep	☐ Yes	☐ No	Irritable	☐ Yes	☐ No
Difficult to be put on a schedule	☐ Yes	☐ No	Alert	☐ Yes	☐ No
Easy to comfort	☐ Yes	☐ No	Affectionate	☐ Yes	☐ No
Overactive/in constant motion	☐ Yes	☐ No	Sociable	☐ Yes	☐ No

Was the child breast fed? ☐ Yes ☐ No For how long?_____

When was solid food introduced?_____

Was there any evidence of food intolerance? ☐ Yes ☐ No

If so, to what?_____

Developmental History:

How old was your child when (s)he:	Average age	Aproximate age	If not sure, please estimate		
Sat	4-7 mos		Early	Average	Late
Crawled	7-10 mos		Early	Average	Late
Walked	12-17 mos		Early	Average	Late
Toilet Trained	18-36 mos		Early	Average	Late
Said First words	12-17 mos		Early	Average	Late
Began using sentences	36-60 mos		Early	Average	Late

Speech and Language:

Has his/her hearing ever been checked? ☐ Yes ☐ No
Does this child have a history of ear infections? ☐ Yes ☐ No
Has (s)he ever had tubes placed in his/her ears? ☐ Yes ☐ No

Last hearing/audiology evaluation: Place_____ Date_____

Does your child have:
Any speech problems/difficulty speaking? ☐ Yes ☐ No
Have trouble understanding what is said to him/her? ☐ Yes ☐ No
Has (s)he ever had a Speech and Language evaluation? ☐ Yes ☐ No
Where?_____ When?_____
RESULTS:_____
Has (s)he ever had Speech/Language therapy? ☐ Yes ☐ No
Is (s)he currently receiving Speech/Language therapy? ☐ Yes ☐ No
If yes, where:_____
Frequency:_____

Motor Skills:

Does this child have fine motor problems (writing, drawing)? ☐ Yes ☐ No
Has (s)he ever had an Occupational Therapy (OT) evaluation? ☐ Yes ☐ No
Is (s)he currently receiving OT services? ☐ Yes ☐ No
If yes, where:_____
Frequency:_____
Does(s)he have any gross motor problems (walking, running)? ☐ Yes ☐ No
Has (s)he ever had a Physical Therapy (PT) evaluation? ☐ Yes ☐ No
Is (s)he currently receiving PT services? ☐ Yes ☐ No
If yes, where:_____
Frequency:_____

Does this child use any adaptive services (braces)? ☐ Yes ☐ No

If yes, please describe:_____

Vision:

Has your child ever been to an eye doctor? ☐ Yes ☐ No

Most recent date:_____

Does your child wear glasses? ☐ Yes ☐ No

If yes, why?_____

Has your child ever been assessed for/ diagnosed with:

☐ Binocular vision ☐ Convergence Insuffiency

☐ Other Convergence Issues ☐ Fixation Issues

IMPORTANT: if a child wears glasses, please bring them to the appointment

Medical History:

Is your child regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath

☐ Naturopath ☐ Dentist ☐ Other:_____

Has your child had the following childhood or other diseases:

☐ Bronchitis	☐ Allergies	☐ Abdominal pains	☐ Pertussis	☐ Scarlet fever
☐ Bed wetting	☐ Asthma	☐ Croup	☐ Measles	☐ Meningitis
☐ Seizures	☐ Chronic Colds	☐ Colic	☐ Mumps	☐ Rubella
☐ Chicken pox	☐ Ear infections			

Does your child have/had braces on his/her teeth? ☐ Yes ☐ No

Does your child have any amalgam fillings? How many? ☐ Yes ☐ No

How many continuous hours is your child sleeping? _____

Is (s)he well rested in the morning? ☐ Yes ☐ No

Does your child suffer from sleep difficulties? ☐ Yes ☐ No

Does your child have problems with food eating? ☐ Yes ☐ No

Is your child a fussy eater? ☐ Yes ☐ No

Does your child have issues with hygiene/cleanliness? ☐ Yes ☐ No

Does your child complain of any ongoing physical pain? ☐ Yes ☐ No

Does your child suffer from dry skin, dandruff, dehydration? ☐ Yes ☐ No

Has your child received any vaccines? ☐ Yes ☐ No

If yes, please list:_____

Were there any of the following adverse reactions noticed?

☐ Inconsolable crying	☐ High fever	☐ Sleep disruptions afterwards
☐ Lethargy	☐ Irritability	☐ Developed allergies

How many courses of antibiotics has your child received? _____

Has your child taken any other prescription medication in the past? ☐ Yes ☐ No
If yes, what are/were they?

_____

_____

Is your child exposed to a toxic environment (including passive smoking)? ☐ Yes ☐ No
Has your child had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No
Please List:_____

_____

_____

_____

School History

Does your child like/enjoy school? ☐ Yes ☐ No
If not, why not:_____

_____

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S	W	Math	S	W	Music	S	W
History	S	W	Science	S	W	Creative Writing	S	W
Gym/Sports	S	W	Other languages	S	W	Other:	S	W
Art	S	W						

Concentration	S	W	Organization	S	W	Test Preparation	S	W
Hand writing	S	W	Planning	S	W	Good behavior	S	W
Memorizing	S	W	Reading Quickly	S	W	Vocab and expression	S	W
Creative writing	S	W	Spelling	S	W	Paying Attention	S	W
Reading Comprehension	S	W	Getting work done on time	S	W	Understanding concepts	S	W

Is getting homework done a struggle? ☐ Yes ☐ No

Behavior/Mental Health

Describe any sport or activity the child is involved in:_____

_____

_____

Indicate how many hours per week of "screen time" the child gets:

Computer:_____ Smart devices:_____

Television:_____

Describe your child's family relationships with parents and siblings:

_____

_____

Does your child have many friends? ☐ Yes ☐ No

Does your child seem to excel at or struggle to build relationships with peers? ☐ Excel ☐ Struggle ☐ Neither

If they struggle, why do you think that is?

_____

_____

What problems does your child have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being teased

☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate

☐ Being Bullied ☐ Jealous of peers

Does your child have self esteem issues? ☐ Yes ☐ No

Which of the following has your child experienced in the last 12 months?

☐ None ☐ Mother pregnant ☐ Parents separation/divorce

☐ Change of School ☐ Birth of sibling ☐ Serious illness/injury in immediate family

☐ Parent losing a job ☐ Death of immediate family member ☐ Move to a new home

Other:_____

Do you feel that your child exhibits any of the following symptoms more often than a typical child of his/her age?

☐ Often touchy/easily annoyed
☐ Often defies adult rules
☐ Often angry/resentful
☐ Often argues with adults
☐ Often loses temper
☐ Blames others for mistake
☐ Deliberately annoys
☐ Often spiteful/vindictive
☐ Refuses to go to school
☐ Repeated nightmares
☐ Unusual fears
☐ Panic attacks
☐ Self conscious/clings
☐ Excessive need for reassurance
☐ Self injurious behavior
☐ Worry of future events
☐ Repeats certain actions
☐ Head/Stomach aches
☐ Difficulty maintaining friendships
☐ Often bullies/threatens
☐ Initiate physical fights
☐ Ever been arrested
☐ Physically cruel to others
☐ Physically cruel to animals
☐ Motor or vocal tics
☐ Destroys property
☐ Deliberately sets fire
☐ Lies often
☐ Steals
☐ Has run away
☐ Extreme mood swings
☐ Does not show emotions
☐ Overacts to touch/noise
☐ Strange or bizarre ideas
☐ Used drugs in the past
☐ Poor social interactions
☐ Gets upset with changes in routine
☐ Often irritable
☐ Changes in appetite
☐ Diminished interest
☐ Sleep problems
☐ Restlessness or slowed down
☐ Fatigues/low energy
☐ Feels worthless
☐ Becomes tearful easily
☐ Often sad
☐ Indecisive can't think
☐ Thinks about death
☐ Talks about suicide
☐ Hurts self
☐ Currently uses drugs
☐ Currently drinks alcohol
☐ Used alcohol in the past
☐ Can't stop thinking about things
☐ Excessive occupation with objects

Please place a check mark in the column which best describes your child	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
Often has difficulty sustaining attention in tasks or play activities				
Often does not seem to listen when spoken directly to				
Often does not follow through on instructions and fails to finish schoolwork, or chores				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in other situation in which remaining seated is expected				
Often runs about or climbs excessively in situations where it is inappropriate				
Often has difficulty playing or engaging in leisurely activities quietly				
Is often “on the go” or acts as if “driven by a motor”				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others				

Reason For Assessment

Please describe in your own words what concerns you have about this child. Also, please add any information that you feel is important and may be helpful in our assessment.

What specific questions do you have that you hope the evaluation will answer?

Your Name:_____ Relationship to child:_____

Date__/___/_____