Pediatric Intake Form **West Valley Chiropractic Centre**

Name: _____

Parent/Guardian Name: _____ Date of Birth _____ Age _____

_____ Sex: _____ Weights: _____ Height: _____

Address: _____ Alberta Health Care # _____

City: _____ Prov: _____ PC_____ Referred By: _____

Phone (H)_____ Other_____ Email: _____

Chiropractic History

Have you previously seen a chiropractor? o Yes o No Reason _____ Did they take x-rays? o Yes o No

If yes, when was your last visit and how long did you receive care? _____

Main Concern for today's visit: _____

Pain or problem started on _____ Why do you think it started? _____

Does anything make it worse? o Yes o No _____

Does anything make it better? o Yes o No _____

Is it worse during certain times of day? _____ Is it progressively getting worse? o Yes o No

Other Doctors seen: _____ Any home Remedies? _____

Check any of the following conditions your child has suffered from during the past six months:

o Difficult Breastfeeding o Ear Infections o Seizures o Chronic Colds o Headaches o Asthma/Allergies o ADHD / ADD

o Digestive Problems o Recurring Fever o Growing / Back Pains o Colic o Bed Wetting o Temper Tantrums o Scoliosis

o Difficulty Sleeping o Other _____

Medical History:

Pediatrician: _____ Date Last Visit: _____ Reason: _____

Vaccination History: _____

Antibiotics or other prescription history: _____ In the last six months: _____

Family medical conditions/history: _____

Childhood Diseases:

Chicken Pox: Age _____ N/A Measles: Age _____ N/A Mumps: Age _____ N/A Rubella: Age _____ N/A

Whooping Cough: Age _____ N/A Rubeola: Age _____ N/A Other: _____ Age _____

Prenatal History:

Name of Obstetrician / Midwife: _____ Location of Birth: o Hospital o Birthing Centre o Home

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Complications during pregnancy? o Yes o No What Type? _____

Cigarette / Alcohol use during pregnancy? o Yes o No

Medications during pregnancy? o Yes o No What Type? _____

Birth Interventions: o Forceps o Vacuum Extraction o Caesarean Section (o Emergency o Planned)

Complications during delivery? o Yes o No What kind:_____

Genetic disorders or disabilities? o Yes o No What kind:_____

Feeding History:

Breast fed: o Yes o No How long:_____ Formula fed: o Yes o No How long: _____

Introduction to: Solids at: _____ months Cow's milk at _____ months

Food/Juice allergies or intolerances: o Yes o No List: _____

Developmental History:

At how many months was your child able to: ____ Respond to sound ____ Respond to visual stimuli ____ Hold head up

____ Sit up ____ Cross crawl ____ Stand alone ____ Walk alone

Accident/Trauma/Injury History:

Involved in Sports: o Yes o No What type: _____

Car accidents: o Yes o No How many: _____ Approximate dates: _____

Other traumas/accidents/injuries: o Yes o No What kind:_____

Surgeries: o Yes o No What type: _____When:_____

Signature_____ Witness _____ Date _____