

Child's Name: _____ Date: _____ Patient Number: _____

Parent Names: _____ Sibling's Names & Ages: _____

Child's Age: _____ Birth date: _____ (dd/mm/yyyy) Sex: M F

Address: _____

Home Phone: _____ Other Number: _____

Family doctor's name: _____ Address: _____

Who may we thank for referring you? _____

Has your child ever received chiropractic care? Yes No

If yes, who is your child's previous Doctor of Chiropractic?: _____

The date of last visit: _____

The reason for the last visit: _____

Other professionals seen for this condition: _____

Results with that treatment? _____

Recent tests done (list date beside): Bloodwork _____ Urine _____ X-Rays _____

Other: explain _____

Please tick the purpose for your child's visit:

crisis management early detection of problems prevention wellness

maximizing normal growth and development other: _____

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: _____

Date: _____

Signature: _____

Witness: _____

Doctor of Chiropractic:
Address:

Present Health Concerns

Major _____

Minor _____

When did this problem begin? _____

Is this problem: occasional frequent constant intermittent

Does problem radiate? Yes No If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No

If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

Often seemingly unrelated symptoms can manifest as other health concerns..

Please tick if your child has had any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chest pressure | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> breast pain | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> irritability | <input type="checkbox"/> frequent colds | <input type="checkbox"/> dental problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> fevers |
| <input type="checkbox"/> depression | <input type="checkbox"/> sore throats | <input type="checkbox"/> heart palpitations |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> numbness in feet |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> bronchitis | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> poor coordination | <input type="checkbox"/> pneumonia | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> constipation | <input type="checkbox"/> radiating pain |
| <input type="checkbox"/> light sensitivity | <input type="checkbox"/> diarrhea | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> urinary problems | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> reduced mobility | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> stiffness |

Other: _____

Birth History

What was the child's gestational age at birth? _____ weeks.

Birth weight _____ lbs _____ oz

Birth length _____ inches

Was your child's birth: at home in a birthing center hospital other

Was the birth considered: medical midwife Duration of birth: _____ hours

Was child born: cephalic (head first) breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labour: spontaneous induced

Were medications or epidurals given to the mother during birth? Yes No

APGAR score: at Birth _____/10 After 5 minutes _____/10

Is there anything else we need to know about the birth Yes No

Growth & Development

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

If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____

Hold up head _____

Vocalize _____

Sit alone _____

Teethe _____

Crawl _____

Walk _____

Does your child sleep: front back side

Do you consider the child's sleeping pattern normal? Yes No How many hours per day? _____

If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant?

bruising

odd shaped head

stuck in birth canal

fast or excessively long birth

respiratory depression

cord around neck

Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No

If yes, please explain _____

Any sports played? _____ Is

a school backpack used? Yes No

Is it heavy or light?

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child on or have taken any medications? _____

During the mother's pregnancy:

Did the mother smoke? Yes No How much? _____

Drink alcohol? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, describe: _____

Any supplements taken during pregnancy? Yes No If yes, describe: _____

Any drugs taken during pregnancy? Yes No _____

Any ultrasounds? Yes No How many: _____ Reasons for being done: _____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? Yes No

If yes, please explain _____

Any pets at home? Yes No _____

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

Is the diet organic? Yes No Do you use 'green products' in your home for cleaning? Yes No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? Never On

weekends A few times per week Daily Nearly each meal On special occasions

Psychosocial Stressors

Any difficulties with lactation? Yes No _____

Any problems with bonding? Yes No _____

Any behavioral problems? Yes No _____

Any inattention? Yes No _____

Any hyperactivity or restlessness? Yes No _____

Any compulsiveness? Yes No _____

Any difficulties at daycare or school? Yes No _____

Any challenges with learning deficiencies? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Any prolonged temper tantrums or separation anxiety? Yes No _____

Is the child in day care Yes No _____

Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work Yes No _____

Is the child home schooled? Yes No _____ by Whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

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and
Stay Well.**



First name : _____ Last name : _____

Date of birth : ____ / ____ / ____

Email address : _____

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