March 2019

CHILD CHIROPRACTIC - INTAKE FORM

BEACON HILL
CHIROPRACTIC AND MASSAGE

Children (0-9)

Child's Full Name: _____ ***M / F*** **Date:** _____

Date of Birth (M/D/Y): _____ **Age:** _____ ***AHC #:*** _____

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

Parent/Guardian Name(s): _____ **Phone Number:** _____

Alternate Emergency Contact: _____ **Phone Number:** _____

Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: _____ **Initials:** _____

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _____ ◯ Person: _____

◯ Current patient: _____

Experience with Chiropractic

Has your child ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? _____

Doctor's name? _____ Reason for visit? _____

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ Birth ◯ Injury ◯ Fall ◯ Car accident ◯ Other: _____

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: _____

When did this condition begin? _____ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Sleeping ◯ Eating ◯ Daily routine ◯ Movement

Please explain: _____

Have you seen anyone else for this condition? Doctor/clinician's name: _____

Type of treatment: _____ Result: _____

CHILD'S CURRENT HEALTH STATUS

Has your child ever been hospitalized? ◯ Yes ◯ No Explain: _____

Had a severe fall? ◯ Yes ◯ No Explain: _____

Been in a car accident? ◯ Yes ◯ No Explain: _____

Has a severe illness? ◯ Yes ◯ No Explain: _____

Had a surgery? ◯ Yes ◯ No Explain: _____

Taken antibiotics? ◯ Yes ◯ No Explain: _____

Does your child have gastrointestinal issues? ◯ Yes ◯ No Explain: _____

Does your child have difficulty interacting with schoolmates or friends? ◯ Yes ◯ No

Have you noticed that your child twitches, shakes or exhibits rocking behavior? ◯ Yes ◯ No

Does your child's social/emotional development seem normal for his/her age? ◯ Yes ◯ No Explain: _____

Describe your child's sleep habits: _____

VACCINATIONS

Have you chosen to vaccinate your child? ◯ Yes ◯ No

If yes, is your child following: ◯ Standard vaccine schedule ◯ Modified vaccine schedule

Describe any reactions (either immediate or delayed) to vaccinations: _____

_____

FULL NAME: _____

Please **CHECK** any current/past conditions

CHILDREN SPECIFIC
- ◯ Bed wetting
- ◯ Colic
- ◯ Developmental delay
- ◯ Foot/gait problems
- ◯ Frequent colds
- ◯ Insomnia/sleep issues
- ◯ Irritability
- ◯ Low energy
- ◯ Nightmares
- ◯ Pink eye
- ◯ Teeth grinding
- ◯ Tubes in ears
- ◯ Urinary tract infections

CARDIOVASCULAR
- ◯ Heart problems

MUSCLE/BONE/JOINT/DISC
- ◯ Arthritis
- ◯ Fractures/Breaks: _____
- ◯ Trauma/Falls
- ◯ Weakness/Instability

GASTROINTESTINAL
- ◯ Constipation
- ◯ Digestive problems
- ◯ Nausea/Vomiting
- ◯ Other issues: _____ _____

NEUROLOGICAL
- ◯ Headaches
- ◯ Loss of motor control
- ◯ Seizures
- ◯ Other issues: _____ _____

HEAD & NECK
- ◯ Ear infection/ache
- ◯ Neck pain
- ◯ Sinus problems
- ◯ Vision problems

RESPIRATORY
- ◯ Asthma
- ◯ Difficulty breathing
- ◯ Other issues: _____ _____

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Cancer: _____ _____ (radiation/chemotherapy)
- ◯ Diabetes (I / II / III)
- ◯ Other:_____

ALLERGIES

Allergic to: _____ _____

Reaction: _____ _____

- ◯ EpiPen? YES / NO

FAMILY HEALTH HISTORY

◯ Arthritis ◯ Depression ◯ Digestive issues/IBS ◯ High blood pressure ◯ Osteoporosis
◯ Cancer ◯ Diabetes ◯ Heart disease ◯ Multiple sclerosis ◯ Stroke

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications your child is currently taking. If you are unsure of their medication it is imperative that you let us know during your next visit.

Medications	Dosage	Duration	Reason
Nutritional supplements	Dosage	Duration	Reason

If patient is 0-4 years of age

MOTHER'S PREGNANCY

How was pregnancy overall? _____

Any illnesses during pregnancy? ◯ Yes ◯ No Explain: _____

Was medication taken? ◯ Yes ◯ No Explain: _____

Smoke/alcohol consumed? ◯ Yes ◯ No

LABOUR

How long was labor? _____ hours Was labor doctor assisted? ◯ Yes ◯ No Labor chemically induced? ◯ Yes ◯ No

Was delivery premature? ◯ Yes ◯ No C-section performed? ◯ Yes ◯ No Were forceps or vacuum used? ◯ Yes ◯ No

Baby weight at birth: _____ lbs Length at birth: _____ inches

Check any your child experienced after birth:

◯ Displaced/broken joints ◯ Failure/minimal crawling ◯ Feeding problems ◯ Jaundice ◯ Breathing problems ◯ Sleep issues

What changes, if any, in your child's health or behavior would you like to accomplish? _____

_____

_____

_____