Apr 2024

CHILD CHIROPRACTIC - INTAKE FORM

Children (0-9)

Child's Name: ____ ***M / F / Other*** **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: _______________ ◯ Current patient: ___________________________

Experience with Chiropractic

Have you 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: ◯ 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: ___________________________

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? ______________________________

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