Fredericton Family Chiropractic:
A Creating Wellness
Centre

Child Welcome
4-13 Years

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www.FrederictonFamilyChiropractic.ca

1 Personal Information

Today's Date (mm/dd/yy): _____/_____/_____

Name of child (first/last): _____

Age: _____ Gender: M ☐ F ☐ Date of Birth (mm/dd/yy): _____/_____/_____

Name of guardian(s): _____

Have you, the guardian(s) ever received chiropractic care? Yes ☐ No ☐

Address: _____

City: _____ Province: _____ Postal code: _____

Phone (Home): _____ (Other): _____

May we leave phone messages, if need be? Yes ☐ No ☐

Email: _____

May we communicate with you via email? Yes ☐ No ☐

How did you hear about us? _____

EMERGENCY CONTACT

Name (first/last): _____

Relationship to child: _____

Phone (Home): _____ (Alternate): _____

2

Healthcare History

Has your child had previous chiropractic care? Yes ☐ No ☐

If yes, where? _____ When? _____

Date and reason for last visit: _____

Do you feel their previous chiropractic care was effective? Yes ☐ No ☐

Please explain: _____

_____

Child's Family Medical Doctor: _____ Phone:_____

Date and reason for last visit: _____

_____

May we contact your family doctor regarding care in this office, if necessary? Yes ☐ No ☐

Has your child seen any other healthcare professionals in the last 6-12 months regarding their health? (Naturopathic Doctor, Pediatrician, Physiotherapist, Massage Therapist, Allergy Elimination Specialist, etc): _____

_____

_____

3

Chiropractic - The Best Kept Secret For Optimizing Your Health Potential

As a full spectrum chiropractic office, we focus on your child's potential for health. Our goals are to address the issues that brought you into this office today and to offer your child and family the opportunity of improved health well into the future.

Many of the common health challenges that adults experience have their origins during the developmental years – some starting as early as birth. LAYERS of damage to the spine and nervous system accumulate as a result of traumas, toxins and emotional stress.

Please answer the following questions to give us a better understanding about your child's state of health and wellness. It is important we understand the WHOLE picture so we can appreciate all the factors that may be impeding your child's ability to heal properly.

Why have you decided to have your child evaluated by a Chiropractor (check all that apply)?

- ☐ He/she is continuing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value of getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/she has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

4

Symptom Profile

If you have brought your child in for a specific health challenge or symptom, please answer the following questions. **(If not, please skip ahead to Page 4).**

Please describe your child's current symptom or health challenge: _____

_____

_____

_____

_____

Does your child appear to be in pain or discomfort? Yes ☐ No ☐

When did this begin? _____

Has your child had this problem before? _____

Is it getting better, worse or staying the same? _____

Was the onset sudden or gradual? _____

Has your child seen any other health care professional regarding this complaint? Yes ☐ No ☐

If yes, whom? _____

What treatment did your child receive? _____

Has your child taken any medication for this complaint? _____

Has your child had any x-rays, blood tests or any other tests/imaging in relation to this complaint?

_____

_____

_____

Symptom Profile cont'

COMMUNICATING SIGNALS

When the spine and nervous system are not functioning at its best, this will usually manifest as a symptom(s) or a problem with healing or immune function. This is simply a signal to us that things are not running smoothly internally. To help us understand the full picture, please answer the following questions as thoroughly as you can.

CURRENT

- ☐ Asthma
- ☐ Respiratory Tract Infections
- ☐ Sinus Problems
- ☐ Ear Infections
- ☐ Tonsillitis
- ☐ Strep Throat
- ☐ Frequent Colds / Croup
- ☐ Recurring Fevers
- ☐ Eczema
- ☐ Rashes
- ☐ Allergies
- ☐ Food Sensitivities
- ☐ Digestive Problems
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Flatulence
- ☐ Headaches / Migraines
- ☐ Neck Pain
- ☐ Torticollis / Head Tilt
- ☐ Trouble Feeding on One Side
- ☐ Back Pain
- ☐ Growing Pains
- ☐ Scoliosis
- ☐ Red, Swollen, Painful Joint
- ☐ Colic
- ☐ Frequent Crying Spells
- ☐ Slow Weight Gain
- ☐ Slow or Absent Reflexes
- ☐ Asymmetrical Crawling or Gait
- ☐ Weight Challenges
- ☐ Bed Wetting
- ☐ Sleep Problems
- ☐ Night Terrors
- ☐ Tip Toe Walking
- ☐ Regression of Milestones
- ☐ Seizures
- ☐ Tremors / Shaking
- ☐ ADD / ADHD
- ☐ Autism / PPD
- ☐ Other: _____

PAST

- ☐ Asthma
- ☐ Respiratory Tract Infections
- ☐ Sinus Problems
- ☐ Ear Infections
- ☐ Tonsillitis
- ☐ Strep Throat
- ☐ Frequent Colds / Croup
- ☐ Recurring Fevers
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- ☐ ADD / ADHD
- ☐ Autism / PPD
- ☐ Other: _____

Child Health History

Physical Stress or Challenges

Please describe your child's birth process and describe any birth trauma: (position at birth, vaginal / C-section, use of forceps, vacuum, epidural, induction, length of labor, face or head bruising, etc.)

_____

_____

Please describe any childhood illnesses, surgeries, serious falls, sports injuries, concussions, car accidents or comment on any repetitive activity your child does regularly (for example: playing an instrument, prolonged computer or console gaming activity, etc):

_____

_____

_____

Chemical Stress or Challenges

Is your child currently taking any medication (over the counter and/or prescription)?

Please list: _____

Previous medications? _____

Vaccinations? _____

Is your child exposed to cigarette toxins daily? Yes ☐ No ☐

Allergies? _____

How many servings of fruit does your child consume each day? 3 or less ☐ 3-5 ☐ 5 or more ☐

How many servings of vegetables do they consume each day? 3 or less ☐ 3-5 ☐ 5 or more ☐

How often does your child consume sugary foods?

>3 times / day ☐ 1-3 times / day ☐ 1-3 times / wk ☐

How often does your child consume processed foods?

>3 times / day ☐ 1-3 times / day ☐ 1-3 times / wk ☐

Does your child drink water on a daily basis? Yes ☐ No ☐

Does your child supplement with Vitamin D? Yes ☐ No ☐ Sometimes ☐ If yes, how much? ____

Does your child supplement with Omega 3? Yes ☐ No ☐ Sometimes ☐

Does your child supplement with probiotics? Yes ☐ No ☐ Sometimes ☐

Child Health History cont'

Emotional Stress or Challenges

List any emotional stressors presently in your child's life and any previous major stressors. (i.e. death in the family, divorce, bullying, bed wetting, etc.)

_____

_____

_____

Do you believe that your child is healthy? Yes ☐ No ☐

Do you believe that your child has healthy coping strategies and a healthy outlet for stress?

Yes ☐ No ☐

Please explain:

_____

_____

_____

Is there anything else you would like to share with us (questions, concerns) that we haven't already addressed? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____