Fredericton Family Chiropractic:
A Creating Wellness Centre

Child Welcome
0-3 Years

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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): _____

_____

_____

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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
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- ☐ ADD / ADHD
- ☐ Autism / PPD
- ☐ Other: _____

5 Prenatal Profile

Complications during pregnancy? Yes No

(brief description if you answered yes) _____

_____

Number of ultrasounds during your pregnancy? _____

Medications and/or vaccinations during pregnancy? _____

Exposure to alcohol and/or cigarettes during pregnancy? _____

Overall, how would you describe your pregnancy (physically and emotionally)?

_____

_____

6 Birth Experience

Location of Birth: Home | Hospital | Birthing Centre | Other

Birth Attendants: | Doula | Midwife | GP | OB | Other

Medications during labor/delivery? _____

Was Pitocin used to induce/ speed up labor? Yes | No

Were your membranes ruptured by a medical professional? Yes | No |

Was your delivery | vaginal or | C-section? If it was a C-section: planned or emergency?

Were any of the following interventions used during delivery? ☐ Forceps ☐ Vacuum

Other: _____

Were there any complications during delivery? Yes | No | If yes, please explain:

_____

How long was your first stage of labor (first contractions to full dialation)? ____ hours

How long was your second stage of labor (pushing to birth)? ____ hours ____ minutes

Was the baby born with any bruising/ markings on their face or head? Yes | No |

Any concerns about misshapen head at birth? Yes No |

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Post Natal History

How many weeks gestation was your baby at birth?____ Birth Weight? ____lbs Birth Length? __inches

If known, APGAR score at: 1 minute ____ /10 5 minutes ____/10

Was your baby ever administered to Neonatal Intensive Care? Yes | __ No __

If yes, for how long and why? _____

Was there any medication given to your baby at birth? Yes No

If yes, what medication and why? _____

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Child Health History

(Some of these questions are for the early months… if your child is beyond this please skip questions that are not applicable for your child)

Infant: How many hours does your baby sleep between feedings? _____ Day _____ Night

Child: How many hours a night does your child sleep? _____

Does your child have any sleep problems? Yes | __ No __ If yes, please explain: _____

_____

How often does your baby/child have a bowel movement? _____/day _____/week

Does your baby/child have any feeding difficulties? Yes | No | If yes, please explain: _____

_____

Is your baby/child currently being breastfed? Yes Exclusively breastfed / Formula supplemented No

If no, did you breastfeed your child previously? Yes No | If yes, how long?_____weeks/months

Does your baby frequently spit up after feeding? Yes No

Does your baby cry often? Yes No If yes, please explain: _____

Does your baby/child pass a lot of intestinal gas? Yes | No

Does your baby/child frequently arch his/her head and neck backwards? Yes No

Has your baby/child shown any sensitivities to foods either in your diet or in their own? Yes __ | No __

If yes, please explain: _____

Has your baby/child shown any difficulty with crawling/walking? Yes __ No __ If yes, please explain:

_____

Child Health History Cont'

Has your child ever fallen from any high places? Yes No _____

Has your child ever been involved in a motor vehicle accident? Yes No _____

Has your child ever been seen on an emergency basis? Yes No _____

Has your child broken any bones? Yes No _____

Has your child had any previous hospitalizations? Yes No _____

Has your child had any previous surgeries? Yes No _____

_____

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:

_____

_____

_____