Canteenwala **Chiropractic**

Pediatrics *Dr. Sony Canteenwala*, D.C.

Full Name:_____ Date of Birth:_____ Age:_____

Parent/Guardian's Names:_____ Sex: □M □F

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Parent/Guardian's Cell/Business Phone: _____Email:_____

Referred By:_____ MHSC 6 digits:_____ 9 digits:_____

***All residents in Manitoba are covered with Manitoba Health for a portion of their first 12 chiropractic adjustments each calendar year.

Other Siblings? □□Yes □No If yes, ages:_____

Has your child had Chiropractic care before? □Yes □No By Whom:_____ When:_____

For what reason:_____

Is your child currently under medical care? □Yes □No If yes, Why?_____

Is your child currently on any medications/supplements □Yes □No If yes, please list:_____

_____

Please tick the purpose for your child's visit:
□ crisis management □ early detection of problems □ prevention □ wellness
□ maximizing normal growth and development □ other:_____

WHY THIS FORM IS IMPORTANT:
Our office focuses on maximizing health. Our goals are to 1) address the issue that brought you to this office and 2) offer the opportunity to learn and improve your health potential for the future. Daily activities, stresses and traumas can accumulate and cause damage to your nervous system. This damage builds layer upon layer to a level at which you may not yet be aware. We need to know what your layers of damage contain, so we ask you to carefully fill out this detailed and important form.

Present Health Concerns:
Your reason for consulting this office:_____

_____

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*
Other professionals seen for this condition: _____
Results with that treatment? _____
Recent tests done (list date beside): □ Bloodwork _____ □ Urine _____ □ X-Rays _____
Other: explain _____

Please Tell Us About Any Stresses Before or At Birth

During Pregnancy:	**Yes**	**No**	**Explain:**
Did you take any drugs/medications?	□□	□□	_____
Did you use any tobacco/alcohol?	□□	□□	_____
Did you have any illnesses?	□□	□□	_____
Did you experience any complications?	□□	□□	_____
What was your stress level? □Low □Moderate □High			_____

During Labour & Delivery:

Delivered by: □ Dr. □ Midwife

Was labour chemically induced? □ □ _____

C-Section delivery? □ □ _____

Forceps/Vacuum delivery? □ □ _____

Was your baby pulled or twisted? □ □ _____

Was it a premature delivery? □ □ _____

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

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

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

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*

During Childhood Has Your Child Suffered From:

□Headaches	□Fainting	□Joint Problems	□Sleeping Problem
□Orthopedic Problems	□Arm Problems	□Constipation	□Respiratory Problems
□Digestive Disorders	□Leg Problems	□ Growing Pains	□Walking Trouble
□Behavioral Problems	□Ruptures/Hernia	□Chronic Ear Infections	□ Allergies to _____
□Bedwetting	□Seizures/Convulsions	□ Backaches	□Asthma
□Dizziness	□Stomach Aches	□Diarrhea	□Digestive Problems
□Neck Problems □	□Reflux □	□Sinus Trouble □	□Colic
□Poor Appetite	□Muscle Pain	□Poor Posture	□Broken Bones
□ADD/ADHD	□Heart Trouble	□Hypertension	□Any Falls (bed, crib, swing,
□Scoliosis	□Anemia	□Colds/Flu	bicycle, high chair, slide, stairs, etc)

Anything Else?_____