Krzyzelewski Chiropractic

Patient Information

Date _____

Name _____

Address _____

City Province Postal Code

Sex: ☐ M ☐ F Age_____

Manitoba Medical # _____ (6 digit) Personal Health ID # _____ (9 digit)

Birthdate _____

Home Phone _____

Parent Name(s) _____

Parent Work Phone _____ Parent Cell Phone _____

Reason for consulting our office _____

How long have they had this condition? _____

What was the possible cause of this condition? _____

Is condition due to an accident? ☐ No ☐ Yes Date of Accident _____

Are you claiming under MPI? ☐ No ☐ Yes Claim # _____

What treatment have they already received for their condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None Other _____

I understand that payment is due at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature of Parent/Guardian _____ Date _____

For Mother to complete:

1. Tell us about your pregnancy:

Did you carry to full term? _____Describe any complications and when they occurred: _____

_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____ For what? _____

What type(s)? _____

2. Tell us about the delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____ Vacuum Extraction? _____

Were you induced? _____Did you have an Epidural? _____ Was it a difficult birth? _____

3. Tell us More:

Did you breastfeed? _____ How Long? _____ What formula after? _____

4. As a baby/toddler (birth to 4 years) did your child experience any of the following?

_____Fall from a change table
_____Tumble down stairs
_____Fall out of crib
_____Involved in car accident
_____Fall off playground equipment
_____Play in jolly jumper
_____Frequent ear infections
_____Tonsillitis
_____Other _____

_____Frequent crying spells
_____Frequent fevers
_____Frequent bouts of diarrhea
_____Constipation
_____Sleeping problems
_____Frequent colds
_____Colic
_____Did not gain weight

Please explain those indicated above: _____

5. As a young child (5 to 12 years) did your child experience any of the following?

_____Fall from a tree
_____Fall off a bicycle
_____Fall off playground equipment
_____Sports accident
_____Car accident
_____Stomach pains
_____Scoliosis

_____Bed wetting
_____Hyperactivity/Autism
_____Learning difficulties
_____Asthma
_____Allergies
_____Leg/knee pains
_____Other _____

Please explain those indicated above: _____

6. As a child or adolescent, has your child experienced any of the following?

_____Headaches	_____Numbness in arms/hands	_____Foot/ankle/knee pains
_____Dizziness	_____Arm/wrist pains	_____Tingling in arms/legs
_____Ringing in ears	_____Sleeping problems	_____Neck/back pains
_____Asthma	_____Allergies	_____Shoulder pains
_____Hyperactivity	_____Stomach problems	_____Growing pains
_____Fatigue	_____Weight gain/loss	_____Other _____

Please explain those indicated above: _____

7. Which of the problems you have checked is the worst? _____

Is this problem: Constant _____ Intermittent _____ Occasional _____ Cyclic _____

8. How long has it persisted? _____

9. When is it at its worst and how does it make your child feel? _____

10. What have you done about it that has not worked? _____

11. What makes it worse? _____

12. What effect does this problem have on your child's body functions? _____

On his/her participation in daily activities? _____

13. Describe any hospital stays: _____

_____

14. Approximately how many times have antibiotics been prescribed and for what conditions? _____

_____

15. List any medications your child is currently taking:

_____ _____

16. Is there anything else you feel we should know? _____