Movement Chiropractic

7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

Infant / Child Chiropractic Confidential Patient History

NAME: _____ DATE: _____

PARENT(S): _____ PHONE: _____

ADDRESS: _____

CITY/TOWN: _____ PROV: _____ POSTAL CODE: _____

BIRTHDATE: DD/ MM/ YY/ AGE: _____ SEX: M / F

MCIB# _____ REFERRED BY: _____

Is this appointment for a general spinal exam? ☐ Yes ☐ No

If no, please indicate the reason for consulting the clinic today: _____

_____

Were there any difficulties or complications during delivery? _____

_____

Was there any assistance during delivery? (e.g. forceps, vacuum, c-section) _____

Have they been an occupant in a motor vehicle that has been involved in an accident? _____

Have there been any major injuries or falls? _____

Is there any difficulty with movement of head or body or awkwardness? _____

If your child is walking, at what age did they start? _____

Is your child very active physically? _____

Has your child experienced any of the following:

- ☐ Asthma
- ☐ Allergies
- ☐ Skin Rashes
- ☐ Frequent Fevers
- ☐ Sinus Infections
- ☐ Ear Infections
- ☐ Vomiting
- ☐ Excessive Abdominal Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty Sleeping
- ☐ Difficulty Concentrating
- ☐ Colic
- ☐ Bed Wetting
- ☐ Unexplained Irritability
- ☐ Seizures
- ☐ Excessive Crying

☐ Other, please explain _____