WELCOME TO
WESTSIDE FAMILY CHIROPRACTIC

live well
adjusted

For Office Use Only

Doctor: _____ **Date:** _____

Referred by: _____ ☐ **MVA** ☐ **WCB** **Date of injury:** _____

Previous Chiro Care: Y / N **Previous Chiro:** _____ **Last adj date:** _____

Spine X-rays? Y / N When: _____ **Facility:** _____

New Patient History Form – 17 years and under

Please relax, breath and smile. We are happy to have you here!

WHY THIS FORM IS IMPORTANT

In our Clinic, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to this office and second, to offer you the opportunity of improved health and wellness in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses your child has faced in his/her lifetime, allowing us to better assess the challenges to your child's health potential.

ABOUT THE CHILD

Name: _____
Last First Initial

Home phone:(____)_____

Email Address (for appointment reminders only): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Birth Date: Day / Month / Year Age: _____ Sex: ☐M ☐F Height: _____ Weight: _____

ABOUT THE PARENT

Name: _____
Last First Initial

Email Address (for appointment reminders only): _____

Occupation:_____ Employer: _____

Work phone: (___)_____ Cell phone: (___)_____

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Certain stresses in your child's life start to accumulate and produce layers of damage to their spine and nervous system. Chiropractic can help minimize the harmful effects these stresses have on your child's body.

CURRENT HEALTH INFORMATION

Why is your child consulting our office (check all that apply)?

☐ Spinal and wellness check-up

☐ Specific problem:_____

_____

☐Yes ☐No ☐N/A Has your child had same or similar symptoms/behaviors in the past?

Explain:_____

☐Yes ☐No ☐N/A Have you seen other doctor(s) for these symptoms/behaviors?

Doctor(s) name:_____

Type of treatment:_____

Results:_____

Does your child's current health interfere with:

☐Daily routine ☐Sleep ☐Other activities:_____

Explain:_____

Do you want better health for your child on a long-term or temporary basis?

☐Long-term ☐Temporary

Are you willing to commit to do what it takes to achieve this? ☐Yes ☐No ☐Depends

CHILD'S HEALTH HISTORY

Please check **(√)** each of the conditions that the child currently has or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and treatment.

☐ Allergies	☐ Recurring Fevers	☐ Digestive problems
☐ Seizures	☐ Sleeping Difficulties	☐ Headaches
☐ Vision problems	☐ Constipation	☐ Irritability
☐ Temper Tantrums	☐ Bed Wetting	☐ Poor Posture
☐ Asthma	☐ Diabetes	☐ Neck/back pain
☐ Attention/Hyperactivity problems	☐ Ear infections/problems	☐ Scoliosis
☐ Breathing problems	☐ Frequent colds	☐ Skin problems
☐ Colic	☐ Other:_____	

Most people experience their first **SUBLUXATION** (misaligned spinal bone/nervous system interference) during the birth process. Please check **(√)** each of the following details that apply to your child's birth.

☐Foreceps / Vacuum ☐Caesarean ☐Breech ☐Blue baby ☐Cord around neck ☐Epidural

CHILD'S CURRENT HEALTH STATUS

☐Yes ☐No Is your child accident-prone?

☐Yes ☐No Has your child been hospitalized or had surgery?

☐Yes ☐No Has your child ever had a severe fall?

☐Yes ☐No Was your child ever involved in a car accident?

☐Yes ☐No Is your child currently taking any medication?

If yes, what:_____

☐Yes ☐No Does your child have difficulty interacting with schoolmates or friends?

☐Yes ☐No Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behaviour?

☐Yes ☐No Have you chosen to vaccinate your child?

☐Yes ☐No ☐N/A Were there any complications from vaccination?

☐Yes ☐No Was your child breast-fed? If yes, at what age was your child weaned?__

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (e.g. a bed, changing table, down stairs, etc). Was this the case with your child? ☐Yes ☐No

Is / Has your child been involved in any high impact contact sports (e.g. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? ☐Yes ☐No

Please list:_____

☐Yes ☐No Are there any other conditions, surgeries or traumas not described above?

Please list:_____

_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

☐Yes ☐No Doctors of Chiropractic work with the nervous system?

☐Yes ☐No The nervous system controls all bodily functions and systems?

☐Yes ☐No If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

☐Yes ☐No Chiropractic is the largest natural healing profession in the world?

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. We look forward to working with you to build better health for your family.

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PRESENTING COMPLAINT: INTENSITY/CHARACTER:

ONSET:

AGGRAVATING/RELIEVING:

LOCATION:

RADIATION/REFERRAL:

ASSOCIATED S&S:

FREQUENCY:

PAST/FAMILY HISTORY:

DURATION:

CODES: OTHER EXAM FINDINGS:

DIAGNOSIS AND CLINICAL IMPRESSIONS:

TREATMENT: ☐ adj ☐ no adj

C0 | C1 C2 C3 C4 C5 C6 C7 | T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 | L1 L2 L3 L4 L5 | IL S

NEXT VISIT: