Southside Chiropractic: Dr. Don MacDonald / Dr. Josh Preston / Dr. Kyla Butz / Dr. Hailey Lutz
7361 - 104 Street, Edmonton, AB, T6E 4B9 Phone 780-439-3444

CONFIDENTIAL PEDIATRIC CASE HISTORY (AGE 5-12)

Please complete this form as fully as you can. Your answers help us provide the best care for your child.

Today's Date:_____

CHILD'S INFORMATION

Child's Full Name:_____ Date of Birth MM/DD/YYYY:_____ Age:_____

Alberta Healthcare #:_____ Sex: **M** ◯ **F** ◯ **Other** ◯

Family Doctor:_____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/guardian Name:_____ Relationship to child:_____

Address:_____ City:_____ Postal Code:_____

Phone #:_____ Second parent/guardian phone #:_____

Email:_____

Emergency contact name & phone:_____

Referred By:_____

BIRTH HISTORY

How was your child delivered at birth? **VAGINAL** ◯ **C-SECTION** ◯ **FORCEPS** ◯ **VACUUM** ◯

REASON FOR TODAY'S VISIT

Main concern/reason for visit:_____

Location of the complaint (be specific):_____

When did it start?_____ **How** did it start (injury, fall, gradual, unknown)_____

How often do you notice it?:_____ How long does it last?:_____

Is it ◯ **CONSTANT** ◯ **COMES & GOES** Does it radiate or travel? **YES** ◯ **NO** ◯ If yes, where?:_____

What makes it WORSE?:_____

What makes it BETTER?:_____

PREVIOUS CARE FOR THIS PROBLEM

What solutions have you already tried for this problem? (MD, physio, massage, acupuncture, medication, home remidies, nothing yet, etc):_____

Has your child had chiropractic care before? **YES** ◯ **NO** ◯ If yes, **when** and **where**?:_____

Have X-rays/scans been taken for this problem? **YES** ◯ **NO** ◯ If yes, **when** and **where**?:_____

PAST HEALTH HISTORY

Check any conditions your child has now or has had in the past:

- ☐ Headaches
- ☐ Neck or back pain
- ☐ Growing pains
- ☐ Fall off playground/bike/stairs
- ☐ Seizures
- ☐ Dizziness
- ☐ Ear infections
- ☐ Frequent colds
- ☐ Sleep problems
- ☐ Broken bones
- ☐ ADHD / ADD
- ☐ Fatigue
- ☐ Asthma
- ☐ Digestive Problems
- ☐ Bedwetting
- ☐ Scoliosis
- ☐ Anxiety
- ☐ Poor Posture
- ☐ Allergies / hay fever
- ☐ Constipation
- ☐ Skin Problems
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Reaction to vaccination
- ☐ Learning difficulties
- ☐ Hyperactivity/autism
- ☐ Delayed developmental milestones

Surgeries or hospital stays (**when**):_____

Current medications / supplements:_____ Allergies:_____

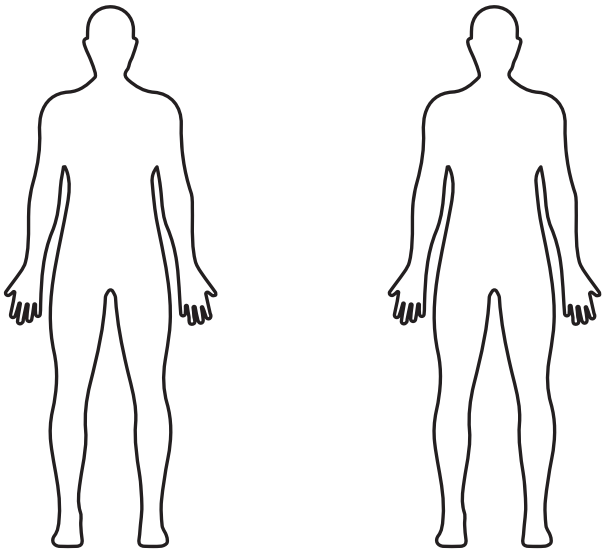
Falls, accidents, or injuries (including sports):_____

Sports & activities your child takes part in:_____

Any family health conditions we should know about:_____

WHERE DOES IT HURT? / ANYTHING ELSE

Mark an X on the diagram of the problem area(s) / where your child feels pain or unusual sensation



FRONT **BACK**

Anything else we should know about your child?

_____

_____

_____

_____

I confirm the information above is accurate and complete to the best of my knowledge, and I am the parent or legal guardian authorized to consent to chiropractic care for this child.

Parent/Guardian Name (printed):_____

Signature:_____