PEDIATRIC CHIROPRACTIC INTAKE & HISTORY

South Trail CHIROPRACTIC

PATIENT INFORMATION

Date: _____

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ Province _____ Postal _____

Primary Contact Phone # _____

Email _____

Birthdate _____ Sex: ☐ Male ☐ Female ☐ Other
MM DD YYYY

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Provincial Health Care Number _____

Health Care Benefits ☐ Yes ☐ No

Mother's Name _____

Mother's Occupation _____

Mother's Phone _____

Mother's Email _____

Father's Name _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you?

_____

As a full spectrum Chiropractic office, 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 potential and wellness services in the future. On a daily basis we experience physical, emotional and chemical stresses that can accumulate and result in serious loss of health potential. 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 you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

HOW CAN WE HELP YOU?

If your child has no symptoms or complaints, and are here for wellness services, please check **here** _____.

If your child is already experiencing a symptom, please describe it: _____

_____

Has your child been treated on an emergency basis? ☐ Yes ☐ No

Please describe: _____

PREGNANCY & BIRTH HISTORY

Did you experience any compilations during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia ☐ Strep B ☐ Nauseau/Vomitting
☐ Pre-Term ☐ Fatigue ☐ Swelling ☐ Other (please describe) _____

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal / Vaginal ☐ Breech
☐ Cesarean ☐ Scheduled/Induced ☐ Epidural ☐ Forceps ☐ Vacuum

Problems during labor / delivery? _____

☐ Antibiotics ☐ Congenital Anomalies ☐ Genetic Disorder or Disability ☐ Jaundice
☐ Respiratory Distress ☐ Extended Hospitalization ☐ Meconium ☐ Other: _____

Infant feeding: ☐ Breast How long: _____ ☐ Formula How Long: _____

Birth Weight: _____ Birth Length: _____ APGAR score: _____

GROWTH AND DEVELOPMENT

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to sound: _____ Respond to visual stimuli: _____ Hold head up: _____

Crawl_____ Sit unsupported: _____ Stand alone: _____ Walk unsupported: _____

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

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No List _____

Has your child ever been in a car accident? ☐ Yes ☐ No List _____

Has your child been seen on an emergency basis? ☐ Yes ☐ No List _____

Any surgeries your child has undergone? ☐ Yes ☐ No List _____

Menarche (Menstruation) ☐ Yes ☐ No Age _____

Any other traumas not described above? ? ☐ Yes ☐ No List _____

Check any of the following conditions your child has suffered from during the last six months:

- ☐ Ear Infections
- ☐ Asthma/Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Surgery
- ☐ Recurring Fevers
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Growing/Back Pains _____
- ☐ Other _____

Has your child ever suffered from (check all that apply)?:

- ☐ Allergies
- ☐ Anemia
- ☐ Arm Problems
- ☐ Asthma
- ☐ Back Aches
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ Broken Bones
- ☐ Chronic Ear Aches
- ☐ Colds/Flu
- ☐ Colic
- ☐ Convulsions/Seizures
- ☐ Delayed Speech
- ☐ Diabetes
- ☐ Digestive Issues (constipation/diarrhea)
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Trouble
- ☐ Hyperactivity
- ☐ Hypertension
- ☐ Jeuvenile Rheumatroid Arthritis
- ☐ Joint Problems
- ☐ Leg Problems
- ☐ Neck Problems
- ☐ Neuritis
- ☐ Orthopedic Problems
- ☐ Paralysis
- ☐ Poor Appetite
- ☐ Ruptures/Hernias
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Walking Problems

Allergies (list):

_____

_____

Medications (list)

_____

_____

Previous Chiropractor _____ Date of last visit _____ Reason _____

Name of Pediatrician: _____ Date of last visit _____ Reason _____

Are you satisfied with the care your child has received there? Yes No

Number of doses of Antibiotics your child has taken: _____ During the last six months: _____ Total during his/her llifetime: _____

Number of prescription medicines your child has taken: _____ During the last six months _____ Total during his/her lifetime: _____

List: _____ Vaccination history:_____

Authorization for Care of Minor

I hereby authorize this office and its Doctor to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature of Parent/Guardian: _____ Date: _____