HANDS ON HEALTH
FAMILY CHIROPRACTIC

Welcome to Hands on Health Family Chiropractic!

Please fill out this form completely and accurately, to the best of your ability.
All the information requested below is necessary for us to serve you in the best way possible.

Today's Date: _____

PEDIATRIC INTAKE FORM

PERSONAL INFORMATION:

Name_____
Age _____ Date of Birth (dd/mm/yyyy)_____ Gender: Male __ Female __
Home Address_____
City _____ Prov_____ Postal Code _____
Parent/Guardian's Name(s): _____
Parent's/Guardian's mobile #(s): (____) _____
Parent's/Guardian's e-mail address: _____
Preferred method of contact: ___email, ___text, ___phone call
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE:

Please describe why you have come to Hands on Health Family Chiropractic today.
_____
_____
_____

TRAUMA HISTORY:

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips? ___Yes ___No
Please Explain:_____

Have you ever broken any bones or sprained any part of your body? ___Yes ___No
Please Explain:_____

Have you ever been hospitalized or had any previous surgeries? ___Yes ___No
Please Explain:_____

HEALTH CARE PRACTITIONER HISTORY:

Previous Chiropractor? __Yes __No Name _____
What City/Town? _____Date of last visit?(mm/yy) _____
Name of Medical Doctor _____
Phone _____Date of last visit? (mm/yy)_____
Other Health Care Professionals: _____

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Do they regularly suffer from or experience any of the following? (Yes=Check No=Leave Blank)							
	Allergies		Digestive Issues		Headache/Migraine		Scoliosis
	Skin Problems		Asthma		Seizures		Colic
	Chronic Colds and/or Flus		Exercise Induced Asthma		ADHD		Bed Wetting
	Ear Infections		Other Respiratory Issues		Growing/Back Pains		Other?

Number of Doses of Antibiotics your child has taken?: Past 6 months? _____ Lifetime? _____
Number of Doses of Prescription Drugs your child has taken?: Past 6 months? _____ Lifetime? _____
Please list all current medications (prescribed or over the counter) and any other notable past meds:
_____
_____
Vaccination History: ___Current with Medical Standard ___Modified/Customized Approach ___Not Vaccinated
Allergies? _____
Notable Family History? _____

PRENATAL HISTORY:

Delivering Practitioner: ___OB/Gyn ___Certified Midwife
Complications during Pregnancy? ___Yes ___No; List _____
Ultrasounds during Pregnancy? ___Yes ___No; How many? _____
Medications during Pregnancy/Delivery? ___Yes ___No; List _____
Cigarette/Alcohol Use during Pregnancy? ___Yes ___No
Place of birth: ___Hospital ___Birthing Center ___Home
Birth Interventions? __Forceps __Vacuum Extraction __Ceasarian, Planned __Ceasarian, Emergency
Genetic Disorders or Disabilities? ___Yes ___No;
List_____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

FEEDING HISTORY:

Breast Fed? __Yes __No; How long? _____ Formula Fed?__Yes __No; How long?_____
What type? _____
Solids Introduced at _____ months; What were the first solids? _____
Cow's Milk introduced? ___Yes ___No; If so, at what age? _____
Food Allergies? ___Yes ___No; List _____

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DEVELOPMENTAL HISTORY:

At what age was your child able to:		Hold head up?
Sit up unassisted?	Cross Crawl?	Walk unassisted?

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie: 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 or contact type sports (ie: soccer, football, hockey, gymnastics, baseball, cheerleading, martial arts, etc)? ___Yes ___No; Circle above or list _____
_____
Has your child ever been involved in a Car Accident? ___Yes ___No; When _____
Has your child been to the Emergency Room? ___Yes ___No; When and for what emergency:
_____
Has your child reached Puberty? ___Yes ___No; Age of Menarche: _____

FINANCIAL INFORMATION:

Payment in full is expected on all first visit services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing. We accept Visa, Mastercard, Interac, AMEX, Cash or Cheque.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. You are responsible for payment of all services at the time of service. We will gladly supply detailed receipts for you to submit to your insurance company for reimbursement.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

AUTHORIZATION FOR CARE OF A MINOR: I hereby authorize the doctors at Hands on Health Family Chiropractic to administer care to my Son/Daughter that is determined to be clinically necessary and mutually agreed upon.

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

Name of Parent/Guardian (Please Print):_____
Name Of Child:_____
Signature_____ Today's Date_____

Thank you for choosing Hands on Health Family Chiropractic.
We look forward to helping your child improve their health and well-being.

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