



## Child New Patient Application

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_  
Day Month Year

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Birth Date (DD/MM/YYYY): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Mother's Guardian's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Father's Guardian's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_  Subscribe me to your Monthly Newsletter

Who may we thank for referring you to our office? \_\_\_\_\_

Reason for contacting our office: \_\_\_\_\_  
\_\_\_\_\_

Other professionals seen for this concern: \_\_\_\_\_

Please list treatments and results: \_\_\_\_\_

Other health concerns: \_\_\_\_\_  
\_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Date of last visit (DD/MM/YYYY): \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Date of last visit (DD/MM/YYYY): \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_

I authorize the Cafe of Life Chiropractic Studio and team to perform a comprehensive examination of my child's spine and nervous system.

Guardian's Name: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_\_



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## Birth History

Please check all that apply:

Hospital  Home Birth  Birthing Center  Midwife  Forceps  Vacuum Extraction  C--Section  Induced

Other complications during birth?  No  Yes \_\_\_\_\_

Medications given to mother during labour?  No  Yes \_\_\_\_\_

Duration of birth: \_\_\_\_\_ hours APGAR at birth: \_\_\_\_\_ APGAR after 5 minutes: \_\_\_\_\_

Was the infant alert and responsive within 12 hours of delivery?  No  Yes If no, explain: \_\_\_\_\_

## Growth and Development

Any signs that your child is not developing properly?  No  Yes \_\_\_\_\_

Any growing pains?  No  Yes \_\_\_\_\_

How many times has your child been sick in the last year? \_\_\_\_\_

Do sleeping patterns seem normal to you? \_\_\_\_\_

## Emotional Stressors

Please rate on a scale of 1-10 (10 being the most) the mother's stress during pregnancy: \_\_\_\_\_

Was this child allowed to bond immediately after delivery  No  Yes \_\_\_\_\_

Any behavioural problems?  No  Yes \_\_\_\_\_

Any  Night terrors  Sleep Walking or  Difficulty sleeping? \_\_\_\_\_

Average number of hours of television/computer/ipad/ipod/video games per week? \_\_\_\_\_



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## Chemical Stressors

Please rate on a scale of 1-10 (10 being the best) the mother's diet during pregnancy: \_\_\_\_\_

Mother smoked during pregnancy?  No  Yes Any smokers at home?  No  Yes \_\_\_\_\_

Drugs taken during pregnancy?  No  Yes If yes, which ones: \_\_\_\_\_

Ultrasounds during pregnancy?  No  Yes If yes, how many? \_\_\_\_\_

Any invasive procedures (amniocentesis, CVS)?  No  Yes \_\_\_\_\_

Was this child breast fed?  No  Yes If yes, for how long? \_\_\_\_\_

Was formula introduced?  No  Yes At what age? \_\_\_\_\_

Was cow's milk introduced?  No  Yes At what age? \_\_\_\_\_

Food intolerances?  No  Yes If yes, which foods? \_\_\_\_\_

Number of doses of antibiotics your child has taken: \_\_\_\_\_

Other prescription medication your child has taken: \_\_\_\_\_

Vaccination history: \_\_\_\_\_

Vaccine reactions (please check):  High pitched screaming  Non-stop crying  Fever  Rashes  Hives  Convulsions

Seizures  Other: \_\_\_\_\_

Any digestive problems?  No  Yes \_\_\_\_\_

Any skin problems:  No  Yes \_\_\_\_\_

Any allergies?  No  Yes If yes, which ones: \_\_\_\_\_

\_\_\_\_\_



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## Physical Stressors

Any traumas during pregnancy?  No  Yes \_\_\_\_\_

Any evidence of birth trauma:  Bruises  Odd shaped head  Stuck in birth canal  Excessively long birth

Respiratory problems  Cord around neck  Other: \_\_\_\_\_

Any falls from couches, beds, change tables?  No  Yes \_\_\_\_\_

Any traumas with bruising, cuts, stitches, fractures?  No  Yes \_\_\_\_\_

Any hospitalizations?  No  Yes \_\_\_\_\_

Any surgeries or organs removed?  No  Yes \_\_\_\_\_

Sports played and age began? \_\_\_\_\_

Weight of school backpack? \_\_\_\_\_

## Additional Information

Anything else you'd like Dr. Joel to know about your child? \_\_\_\_\_

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