CONFIDENTIAL PATIENT INFORMATION for CHILD

Dr. Sandra J. Malpass D.C.

356 Wilson Street East
Ancaster, ON L9G 2C2

Name:_____ Date:_____

Address:_____ City:_____ Postal Code:_____

Telephone:_____-_____-_____ (Bus):_____-_____-_____ (Cell):_____-_____-_____

Date of Birth:_____ Gender:_____Male _____Female
D M Y

Weight:_____ Height:_____

E-Mail Address:_____
Names of Parent /Guardians:_____

Referred by:_____

PURPOSE FOR CONTACTING US?_____

When did this condition begin?_____

Is it Better?_____ Worse?_____ Comes and Goes?_____

Other Doctors seen for this condition:_____

Is this condition interfering with any of the following?

Sleep_____ Daily Routine_____ Sports/Exercise_____

Other (please explain) _____

Any other health concerns? _____

Family history:_____

Previous Chiropractor:_____

Date of Last Visit:_____ Reason: _____

Family Doctor:_____

Date of last visit:_____ Reason:_____

Number of doses of prescription medications your child has taken:

During the past six month:_____ List:_____

Total during lifetime:_____ List:_____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications/Illness during pregnancy?_____

Medications during pregnancy? _____

Location of Birth: Home_____ Hospital_____ Other_____

Complications during delivery? _____

Medications during delivery? _____

Birth Intervention:___Forcepts ___Vacuum Extraction ___Cesarean Section(Emergency or Planned?)

Birth Weight:_____ Birth Length:_____

Nutritional History

Breast Fed: _____Yes _____No How long?_____

Formula Fed: _____Yes _____No How long?_____

Solid Food: _____Yes _____No At what age were they introduced?_____

Food Allergies or Sensitivities? _____

Developmental History

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (e.g. a bed, change table, down stairs, etc). Was this the case with your child?

_____Yes _____No List:_____

Is/has your child been involved in any high impact or contact type sports (e.g. soccer, football, gymnastics, baseball, martial arts, figure skating, etc,)?

_____Yes _____No List:_____

Has your child ever been involved in a car accident?

_____Yes _____No List:_____

Has your child ever been hospitalized, had surgery or been seen on an emergency basis?

_____Yes _____No List:_____

Adolescent History

Our purpose is to improve your child's function and quality of life. Lifestyle stressors can accumulate and

result in loss of function.

Has your child ever had a serious fall or jump(e.g. off a bike, downstairs, out of a tree, off playground equipment, etc)?

_____Yes _____No _____List:_____

On a scale of Poor, Good, Excellent, please describe your child's

Eating Habits:_____Exercise Habits:_____ Sleep Habits:_____

How does your child sleep? _____Side _____ Back _____Stomach

List any Medication, Vitamins or Nutritional Supplements:

_____

Does your child wear orthotics? _____Yes _____No

Please **Check** (√) any symptoms experienced:

_____Headaches _____Difficulty Sleeping _____Pins and Needles in Leg

_____Neck Pain or Stiffness _____Heartburn _____Numbness in Toes

_____Pins and Needles in Arm _____Shortness of Breath _____Constipation

_____Numbness in Fingers _____Chest Pain _____Diarrhea

_____Dizziness _____Stomach Upset _____"Growing Pains"

_____Loss of Balance _____Pain Between Shoulder Blades _____Menstrual Pain or Irregularity

_____Ankle /foot Pain _____Fatigue

_____Sinus Problems _____Low Back Pain

_____Irritability _____Knee Pain

Authorization for Care of a Minor

I hereby authorize Dr. Malpass to examine and administer care to my son/daughter as she deems necessary. I clearly understand and agree that I am personally responsible for payment of all fees and charges by this office.

Date:_____ Signed:_____