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CHIROPRACTIC

Pediatric Intake Form

Background Information

Child's Name:_____ Preferred name if different:_____

Date of Birth:_____ Age: _____ Sex: _____

Height (feet and inches): _____ Weight (pounds): _____

Manitoba Health Numbers: **MHSC (6 digits)**_____ **PHIN (9 digits)**_____

*** Manitoba residents: Manitoba Health pays a portion of your first 7 chiropractic adjustments in a calendar year**

Name of Mother/Guardian:_____ Email Address:_____

Home Phone:_____ Cell Phone:_____

Street Address:_____

Name of Father/Guardian:_____ Email Address:_____

Home Phone (if different):_____ Cell Phone:_____

Street Address (if different):_____

Does The Child Have Siblings? ☐ Yes ☐ No Ages? _____

Is The Child under Regular Medical care? ☐ Yes ☐ No Reason? _____

Has The Child Ever Been Under Chiropractic Care? ☐ Yes ☐ No Reason? _____

How Did You Hear About Our Office? _____

Why is this form so important? Because our office focuses on maximizing health. Our goals are to address the issue that brought you to this office and to offer the opportunity to learn and improve your health potential for the future.

Reason For Visit Today

What Is The Reason For Your Childs Visit?

☐ Wellness ☐ Prevention ☐ Early Detection of Problems ☐ Crisis Management ☐ Maximize normal growth/development

What is Your Child's Health or Symptom Concern:_____

Symptoms Frequency?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (1-25%)

Do You Consider Your Child's Problem Severe? ☐ Yes ☐ No ☐ Sometimes

Your Child's Problem Began How?_____

Have They Had a Previous or Similar Problem? ☐ Yes ☐ No

Your Child's Problem Lasting How Long?_____

Your Child's Symptoms Over Time? ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Anything Make It Worse?_____

Anything Make It Better?_____

Has Your Child Had Previous Care For This?_____

Who Have You Seen For Their Problem?_____

Does your child suffer with any other health condition other than why you are seeking care?

_____

Health History Section MUST BE FILLED OUT IN FULL

Below is a list of conditions which may seem unrelated to the purpose of your child's appointment. However, these questions must be answered carefully as these problems can affect their overall course of chiropractic care.

Check all that apply:

During Labour and Delivery:
- ☐ Greater than 12 hours
- ☐ Caesarian
- ☐ Forceps
- ☐ Vacuum Extraction
- ☐ Fetal monitor used
- ☐ Medications/Epidural
- ☐ Premature Delivery
- ☐ Hospital Birth
- ☐ Home Birth
- ☐ Very fast
- ☐ Complications
- ☐ Induced Labour
- ☐ Problems During Pregnancy

Child Problems Since Birth:
- ☐ Colouring/Jaundice
- ☐ Breathing
- ☐ Nursing
- ☐ Crying/Colic
- ☐ Excessive Spitting Up
- ☐ Sleeping
- ☐ Eating
- ☐ Asthma
- ☐ Earaches/Infections
- ☐ Illness
- ☐ Difficulty Sitting
- ☐ Difficulty Crawling
- ☐ Difficulty Walking

Child Problems Since birth:
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Headaches
- ☐ Extremity Pain
- ☐ Joint Pain/Stiffness
- ☐ Clicking Jaw
- ☐ Irregular Heartbeat
- ☐ Breathing Problems
- ☐ Diarrhea/Constipation
- ☐ Vomiting
- ☐ Indigestion
- ☐ Menstrual Irregularity
- ☐ Bladder troubles

Child Problems Since Birth:
- ☐ Brain Fog
- ☐ ADHD/ADD
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Seizures
- ☐ Dizziness
- ☐ Overeating
- ☐ Under eating
- ☐ Panic attacks
- ☐ Trouble coping with daily living
- ☐ Often feel overwhelmed

Please State Any Family History Of Disease Or Illness: _____

Has Your Child Been Hospitalized or Had Any Surgical Procedures? ☐ Yes ☐ No

Date(s)/Reason: _____

Has Your Child Been In A Motor Vehicle Accident? ☐ Yes ☐ No **Date(s):** _____

Has Your Child Had A Major Fall/Jolt/Impact? ☐ Yes ☐ No **Date(s):** _____

Additional Comments: _____

Has Your Child Been Vaccinated? ☐ Yes ☐ No **Which Ones?** _____

Does Your Child Take Any Prescription/OTC Meds/Vitamins/Supplements? ☐ Yes ☐ No

List and Reason: _____

_____

How Would You Grade Your Childs Diet? ☐ Great ☐ Good ☐ Fair ☐ Bad

Does Your Child Participate In Sports? ☐ Yes ☐ No

Which Ones? _____

How Would You Grade Your Child's Level Of Perceived Stress In Their Life?

☐ None ☐ Mild ☐ Moderate ☐ Extreme

Is There Anything Else You Would Like Us To Know About Your Child?

_____

Parent/Guardian Signature: _____ **Date:** _____