50th Street Chiropractic Clinic

Suite 206 - 12781 50th Street, Edmonton, Alberta, T5A 4L8
Phone (780) 414-1110 Fax (780) 760-1112

(*Pediatric 0-5 years old*)
Confidential Patient Case History

Name _____ Date _____
Name of Parents/Guardians _____
Address _____ City _____ Province _____ POSTAL CODE _____
Ph: (H) _____ (C) _____ (W) _____
E-mail (*Optional*)_____ Date of Birth _____ Sex: F ☐ M ☐

Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?
_____
Appointment Reminders: Reminder Type: Phone or Email _____
Allow our clinic to send email on Educational/Health Materials YES ☐ NO ☐

PRENATAL HISTORY:
Name of Obstetrician/Midwife: _____
Complications during pregnancy: YES ☐ NO ☐, List:_____
Complications during delivery: YES ☐ NO ☐, List: _____
Location of birth: _____Hospital _____ Birthing Centre _____ Home Other: _____
Birth intervention: ____ Forceps ____ Vacuum Extraction ____ Cesarean Section ____ Emergency or Planned
APGAR Scores _____ Birth weight: _____ Birth length: _____
Genetic disorders or disabilities: YES ☐ NO ☐, List: _____

PURPOSE FOR CONTACTING US? Spinal Check-up: _____ Other: _____
_____
_____

Other Doctor seen this condition: YES ☐ NO ☐
Doctors' names and prior treatments: _____
_____

Has this child been under previous Chiropractic care: YES ☐ NO ☐ If YES, Date of Last Visit: _____

Name of Pediatrician: _____ Date of Last Visit: _____
Reason: _____

Have you chosen to vaccinate this child? YES ☐ NO ☐
Any reactions following vaccination (up to 30 days post vaccine):_____

On a scale of 1 to 10, how would you rate this child overall discomfort? (0= no pain, 10= most pain) _____

How long have this child had this condition? _____ had this or similar conditions in the past? YES ☐ NO ☐

List previous testing, x-rays, diagnoses and treatments received for the major complaint: _____
_____
_____
_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes
Is this condition interfering with: ☐ Sleep ☐ Daily routine ☐ Other: _____

Have recently had: ☐ Fever ☐ Chills ☐ Night Sweats ☐ Infection OR ☐ Other illness: _____

Other health problems: _____

According to the National Safety Council, approximately 50% of children fall from a high place during the first year of life (i.e. a bed, changing 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 involved in a car accident: YES ☐ NO ☐, List: _____
Has your child ever had on an emergency: YES ☐ NO ☐, List: _____
Other traumas not described above: YES ☐ NO ☐, List: _____
Hospitalization or prior surgery: YES ☐ NO ☐, List: _____

CHILDHOOD DISEASES:

CHICKEN POX	Y/N AGE ___	MUMPS	Y/N AGE ___	WHOOPING COUGH	Y/N AGE ___
RUBELLA	Y/N AGE ___	RUBEOLA	Y/N AGE ___	OTHER: _____	

DOES YOUR CHILD OR SIBLING(S) SUFFER FROM:

ASTHMA	Y/N AGE ___	SKIN PROBLEMS	Y/N AGE ___	DIFFICULTY SLEEPING	Y/N AGE ___
COLIC	Y/N AGE ___	ALLERGIES	Y/N AGE ___	EAR INFECTIONS	Y/N AGE ___
HYPERACTIVITY	Y/N AGE ___	BED WETTING	Y/N AGE ___	DIGESTIVE DIFFICULTIES	Y/N AGE ___

Has anyone in your family had any of the following diseases? Indicate who the family member(s) underneath the disease.
☐ heart disease ☐ high blood pressure ☐ cancer ☐ stroke ☐ arthritis ☐ diabetes

_____ _____ _____ _____ _____ _____

Emergency Contact: Name: _____ Phone#: _____