

File No: _____

Date: _____

General Information - Child

How do you wish to be contacted by our office regarding your child's care?

Email Phone

Email: _____ Please Initial _____ Expressed consent to receive email communication from the clinic

Child's Name

Last: _____

First: _____

D.O.B. (d/m/yr) _____/_____/_____ Sex: M F

Present Length/Height: _____ Weight: _____

Parent(s) Names:

Last: _____ First: _____

Last: _____ First: _____

Parental Status: Married Divorced Custodial Status: Joint Single Parent

Siblings (include ages): _____

Address: _____

Town/City: _____ Postal Code: _____

Home Phone: () _____ Parent(s) Cell Phone: () _____
() _____

Referred by: _____

How did you decide to choose our office? _____

Family Dr. Name: _____ Phone: () _____

Date of last Medical Doctors visit and reason: _____

Previous Chiropractic Care? YES/ NO If Yes, Doctor's Name: _____

File No: _____

Date: _____

A. HEALTH CONCERNS:

Reason for consulting the office: Spinal Check Other Complaint

Explain: _____

List other care undergone for this complaint (Including medications): _____

Date of onset: ____/____/____ Onset was: Sudden / Gradual / Associated with an event

Duration of problem (episode): _____ minutes / hours / days / months / years

Pattern of problem: Constant / Intermittent / Occasional / Cyclical

Initiating factors: _____

Aggravating factors: _____

Relieving factors: _____

Effects of problems on body function and daily activities: _____

Other Health Concerns: _____

B. HISTORY OF BIRTH: *(Please circle all that apply)*

Hospital Home Medical Midwife

Duration of Gestation: _____ weeks

Assisted birth? YES/NO If yes: forceps / vacuum extraction / c-section / induced labour

Medications delivered to mother at birth? YES/NO If yes, what? _____

Duration of birth: _____

Complications at birth? YES/NO Explain: _____

Was delivery normal? YES/NO Explain: _____

APGAR at Birth (if known): _____ After 5 Minutes: _____

Birth Weight: _____ Birth Length: _____

C. GROWTH AND DEVELOPMENT:

Was the infant alert and responsive within twelve hours of delivery? YES /NO

Has your child met their developmental milestones at the appropriate times? YES /NO

(If no, explain): _____

Does their sleeping pattern seem normal to you? YES /NO Explain: _____

Any health issues (cancer, diabetes, heart disease, etc.) on the mother's side of the family? _____

On the father's side? _____

With siblings? _____

D. CHEMICAL STRESSORS: *Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:*

Was the baby breast-fed? YES /NO How long? _____

Food intolerance? YES /NO Type: _____

Any illness of the mother during pregnancy? _____

Any health supplements taken by the mother during pregnancy? _____

Any drugs taken during pregnancy? _____

Any exposures to ultrasound? YES /NO If so, how many and what was the medical reason: _____

Any invasive procedures? (amniocentesis, CVS, etc.): _____

Any smokers in the home? YES /NO (How much): _____

Any vaccinations? YES /NO Which ones and any reactions: _____

Any antibiotics? YES /NO

For what conditions: _____

Total number of courses of antibiotics to date: _____

E. PSYCHOLOGICAL STRESSORS:

Any difficulties with lactation? YES /NO

Any behavioural problems? YES /NO Onset: _____

Any night terrors, sleep walking, difficulty sleeping? YES /NO Specify: _____

Does your child seem normal for their age? YES /NO Explain: _____

F. TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents)? YES /NO

Any evidence of birth trauma: bruises, odd shaded head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other? _____

Any falls from couches, beds, change tables? YES /NO

Any traumas with bruising, cuts, stitches, fractures? YES /NO

Any hospitalizations? YES /NO Explain: _____

Any surgeries or organs removed? YES /NO Explain: _____
