Welcome to our Chiropractic Clinic:

Patient Information: *Please Print*

Name _____ Consultation Date M/D/Y ____ /____ / ____

Parent(s) Name(s) _____

Age _____ D.O.B M/D/Y ____ / ____ / ____ Gender M/F ____ Height _____ Weight _____

Shoes Size _____ Family Doctor _____

Address _____ City _____ Postal Code _____

Phone: *Home* _____ *Cell* _____

Email _____

Other family members under care _____

Who can we thank for referring you? _____

Has your child ever received Chiropractic care? ○ Yes ○ No

Health Profile

It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Our clinic offers many health services, but we have a focus: to reduce interference to the innate ability of the body to heal itself**.**

"Subluxations", or problems with joint alignment and motion, are conditions that Chiropractors are trained to detect and correct. Dysfunction within the body can be the *result* of subluxations in the spine and their effect on nerve supply. Often other symptoms are seen years before neck or back pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, chemical, and emotional stress that can lead to subluxation. To help us serve you better, please complete the following information.

Authorization for Care of a Minor (under 16)

Parent(s) Name(s) _____

I hereby authorize and consent to the chiropractic evaluation and care of my child. As of this date, I have the legal right to select and authorize health care services for the minor child.

Parent/Guardian Signature _____ **Date M/D/Y** ____ / ____ / ____

Witness Signature _____

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Consultation

If this is not a symptom free-spinal assessment, and you have a specific health concern please describe that here _____

_____

When did this begin? _____

Is this problem: ○ Occasional ○ Frequent ○ Constant ○ Intermittent

What makes it better? _____

What makes it worse? _____

Is it worse during a certain time of day? ○ Yes ○ No If yes, when? _____

Does this interfere with the child's sleep: ○ Sleep ○ Eating ○ Daily Routine

Have you seen another health professional for help with this? ○ Yes ○ No

Who? _____

Treatment results? _____

Other Symptoms

Often seemingly unrelated symptoms may manifest as other health concerns.

Please mark an X in the circles if your child has had any of the following:

○ Headaches	○ Loss of Taste	○ Weight Gain	○ Upper Back Pain
○ Dizziness	○ Light Sensibility	○ Dental Problems	○ Neck Pain
○ Fainting	○ Face Flushed	○ Fevers	○ Low Back Pain
○ Fatigue	○ Cold Sweats	○ Heart Palpitations	○ Stiffness
○ Irritability	○ Bronchitis	○ Chest Pressure	○ Reduced Mobility
○ Depression	○ Pneumonia	○ Breast pain	○ Muscle Cramps
○ Loss of Balance	○ Frequent Colds	○ Heart Burn	○ Numbness in Legs
○ Asthma	○ Loss of Smell	○ Sinus Congestion	○ Numbness in Feet
○ Loss of Memory	○ Sore Throats	○ Weakness	○ Numbness in hands
○ Ears Buzzing	○ Urinary Problems	○ Allergies	○ Ear pain/Infections
○ Constipation	○ Poor Coordination	○ Seizures	○ Sleeping Problems
○ Vision Changes	○ Diarrhea	○ Concentration Loss	○ Bloating/Gas
○ Weight Loss	○ Other _____		
○ Other _____			

History of Birth

Was your child's birth: ○ At home ○ In a birthing centre ○ In a hospital

Was the birth considered: ○ Medical ○ Midwife

Was your child born: ○ Cephalic *(Head First)* ○ Breech *(Feet First)*

Where there any complications? ○ Yes ○ No If yes, please explain _____

_____

Any assistance used during birth: ○ Forceps ○ Vacuum ○ C-Section ○ Episiotomy

Were medications or epidurals given to the mother during birth? ○ Yes ○ No

If yes, what was given? _____

Growth and Development

Has your child reached all the developmental milestones? ○ Yes ○ No If no, please explain

_____

Do you consider the child's sleeping pattern normal? ○ Yes ○ No If no, please explain

_____

Family Health History

Please note any health problems (i.e. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's Family _____

Father's Family _____

Sibling(s) _____

Subluxations and poor health occur because of how our body adapts or doesn't adapt to physical, chemical, and emotional stressors. Please help us see what stressors have been present for your child.

Physical Stressors

Any traumas to the mother during pregnancy? *(i.e falls, accidents, etc.)* ○ Yes ○ No

If yes, please explain _____

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life. Any falls from couches, beds, change tables, etc? ○ Yes ○ No

If yes, please describe _____

Any evidence of birth trauma to the infant?

○ Bruising ○ Odd shaped head ○ Stuck in birth canal
○ Cord around neck ○ Respiratory depression ○ Fast or long birth

Any traumas resulting in stitches, fractures or broken bones? ○ Yes ○ No If yes, please explain_____

Has the child been in a vehicle during an accident? Yes No

Any x-rays taken? ○ Yes ○ No If yes, what area and when? _____

Any hospitalizations or surgeries? ○ Yes ○ No If yes, please explain _____

_____

Which sports has the child been involved in?

○ Football ○ Soccer ○ Hockey ○ Equestrian ○ Basketball
○ Martial arts ○ Dance ○ Gymnastics ○ Lacrosse ○ Other _____

Has the child ever experienced loss of consciousness or a concussion(s)? ○ Yes ○ No

If yes, please explain _____

Is a school backpack used? ○ Yes ○ No if yes, is it: ○ Heavy ○ Light

Does your child use computer/ipad /cell phone/video games? ○ Yes ○ No If yes, which one and for how long per day?_____

Chemical Stressors

Was the child breast fed? ○ Yes ○ No If yes, how long? _____

Formula introduced at what age? ____ What formula? _____

Began solid foods at what age? _____ Types of foods? _____

Food/juice intolerance? ○ Yes ○ No If yes, what type? _____

Chemical Stressors *continued*

During pregnancy did the mother: Smoke? ○ Yes ○ No If yes, how much? _____

Drink? ○ Yes ○ No If yes, how much? _____

Any illnesses during pregnancy? ○ Yes ○ No If yes, what illnesses? _____

_____

Any supplements taken during the pregnancy? ○ Yes ○ No If yes, what supplements?

_____

Any prescription drugs taken during the pregnancy? ○ Yes ○ No If yes, what drugs?

_____

Any procedures during the pregnancy? *(i.e. Amniocentesis, CVS, etc)* ○ Yes ○ No If yes, please explain_____

Did you choose to vaccinate your child? ○ Yes ○ No

Any antibiotics given? ○ Yes ○ No Reason? _____

Any smokers at home? ○ Yes ○ No

Emotional/Psychosocial Stressors

Any difficulties with lactation? ○ Yes ○ No If yes, please describe _____

Any problems with bonding? ○ Yes ○ No If yes, please describe _____

Any behavioural problems? ○ Yes ○ No If yes, please describe _____

Any: ○ Night terrors? ○ Sleep walking? ○ Difficulty sleeping?

Do you feel your child's social and emotional development is normal for their age?

○ Yes ○ No If no, please explain_____

After reviewing this information, the doctor will take a detailed history with you and your child in person. If it sounds like your concerns are a good fit for our skillset, the doctor will perform a thorough examination.

We strive to be your family's most valued health professional and first choice in terms of **getting well and staying well.** Thank-you for choosing our office.

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