Welcome

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Child personal information

First name _____ Last name _____ M / F

Birthday (M/D/Y) / / Age _____ Siblings Y / N

How many? _____ What are their names and ages? _____

Parent's / guardian's information

First name _____ Last name _____

Address _____ Phone number Home _____

_____ Cell _____

City _____ Postal code _____ Work _____

Email _____

May we communicate with you via email (things like appointment reminders and important information) Y ☐ N ☐

Marital status _____ Occupation/s _____

Emergency contact _____ Relationship _____ Phone _____

How did you find us? (who can we thank for referring you?) _____

care card number (MSP) _____

We would like to know about your child's history

Birth weight:_____ Any birth interventions? __Forceps __Vacuum __C-section

Has your child been under Chiropractic care before? Y ? N If yes when? _____

Breast fed Y / N Bottle fed (formula) Y / N _____

Does your child drink Cow's milk? Y / N If yes how much? _____

Does your child have any food / juice allergies or intolerances? Y / N If yes then please list _____

> OVER

Has your child received any medication/s? Y / N If yes then please list all instances (incl dose and duration)

> OVER

Has your child been involved in any high impact or serious falls? Y / N If yes then please list all instances

> OVER

Does your child play contact sports? Y / N If yes then please list _____

> OVER

Has your child ever been involved in a car accident Y / N If yes please describe _____ > OVER

Has your child ever been seen in the hospital emergency room? Y/ N If yes please describe _____

> OVER

Has your child experienced any of the following in the past 6 months?

Ear infections	O	Asthma	O	Seizure	O	Chronic colds	O
Headaches	O	Allergies	O	Digestive problems	O	ADHD	O
Recurring fevers	O	Growing/back pains	O	Colic	O	Bed wetting	O
Scoliosis	O	Temper tantrums	O	Other			

Vaccination history (which vaccinations and when) _____

_____

_____

Has your child experienced any adverse effects following vaccination/s Y / N If yes please describe _____

_____

_____

Specific concern

If you have a specific concern about your child's health

What is your concern? _____

> OVER

When did it begin (date)? _____

_____

How did it begin? _____

> OVER

Does anything make it better? _____

> OVER

Does anything make it worse? _____

> OVER

Has your child's appetite been affected? If yes please describe _____

> OVER

Has your child's sleep been affected? If yes please describe _____

> OVER

Is your child crying excessively? If yes how often? _____ Hours per day _____ Days per week

Is your child in pain? If yes please describe _____

What is the severity of your child's pain? _____ 1-10 (1= virtually no pain / 10 = inconsolable)

Is there anything else you feel the Doctor should know? _____