SNELGROVE CHIROPRACTIC

CHIROPRACTIC PEDIATRIC PATIENT INTRODUCTION

Dear New Patient: It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information about your child. We look forward to working with you to build better health for your family. PLEASE PRINT.

Child's Name; _____ Date: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Telephone (home): _____ Number of Siblings: ____

Date of Birth:_____ Age: _____ Sex: ____ Height: _____ Weight: _____

Referred to us by: _____ Previous Chiropractor: _____

O.H.I.P. Number: _____ Letter Code: _____ Expiry Date: _____

Mother's Name: _____ Mother's Work Phone: _____

Father's Name: _____ Father's Work Phone: _____

Purpose Of This Visit To Our Clinic:

□ Spinal Screening & Wellness Care □ Accident or Fall

□ Illness or other health problem (specify): _____

Have any other Doctors been consulted for this condition? □ Yes □ No. If yes, please provide the Doctor's name(s) and types of treatments: _____

_____

Other Health problems you would like to discuss: _____

Check any of the following conditions your child has suffered from during their lifetime:

□ Ear infections	□ Diarrhea	□ Recurring Fevers	□ Numbness/ Tingling
□ Asthma / Allergies	□ Colic	□ Car Accidents	□ Digestive Problems
□ Poor Appetite	□ Fatigue	□ Dizziness	□ Learning Disabilities
□ Hyperactivity	□ Headaches	□ Stomach Aches	□ Other: _____
□ Bed Wetting	□ Seizures	□ Temper Tantrums	
□ Scoliosis	□ Constipation	□ Sleeping Problems	
□ Diabetes	□ Chronic Colds	□ Back/ Neck/ "Growing" Pains	

Family Health History: _____

Name of Family Physician: _____ Location: _____

Date of last visit: _____ Purpose: _____

Number of doses of antibiotics your child has taken: During the past 6 months: _____

Total during his/her lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____

Please list the medications: _____

Has your child been vaccinated? □ Yes □ No Please list: _____

_____

PRENATAL HISTORY

Name of Obstetrician/ Midwife: _____

Ultrasounds during pregnancy? □ Yes □ No How many: _____ Purpose: _____

Was there any smoking or alcohol consumption during pregnancy? □ Yes □ No How much? _____

Medications during pregnancy or labour/delivery? □ Yes □ No Please list: _____

Complications during pregnancy? □ Yes □ No Please list: _____

Location of birth: □ Hospital □ Birthing Centre □ Home Was an epidural given?: □ Yes □ No

Type of birth: □ Vaginal □ Forceps □ Vacuum extraction □ Breech □ Cesarean (□ Planned or □ Emergency)

Complications during labour/delivery? □ Yes □ No Please list: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____, _____

Genetic disorders or disabilities? □ Yes □ No Please list: _____

FEEDING HISTORY

Breast fed? □ Yes □ No How long? _____ Formula fed? □ Yes □ No How long? _____

Food/ juice allergies or intolerances? □ Yes □ No Please list: _____

Introduced to solid foods at _____ months, Cow's milk at _____ months.

Does your child consume any foods containing: □ Caffeine □ Artificial Sweeteners (i.e. aspartame/ nutrasweet)

DEVELOPMENTAL HISTORY

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by Chiropractor for prevention and early detection of spinal nerve interference (vertebral subluxation).

At what age was your child able to:

Sit up _____ Crawl _____ Stand Alone _____ Walk Alone _____

Respond to sound _____ Follow an object with eyes _____ Hold head up _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc) Was this the case with your child:

□ Yes □ No Please describe the circumstances: _____

Has your child ever been involved in any high impact or contact type of sports (i.e. soccer, football, gymnastics, martial arts, etc) □ Yes □ No Please list: _____

Has your child ever been treated on an emergency basis: □ Yes □ No Please describe: _____

_____

Other injuries or falls not described above: □ Yes □ No Please List: _____

Prior surgery? □ Yes □ No Please list: _____

Menarche (onset of first menstrual period)? □ Yes □ No If yes, age of onset: _____

CHILDHOOD DISEASES: Has your child had any of the following illnesses? (Please indicate age if applicable)

□ Measles (Rubeola) _____ □ Mumps _____ □ Rubella (German Measles) _____

□ Pertussis (Whooping Cough) ___ □ Chicken Pox _____ □ Other _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIAPTION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATON FOR CARE OF MINOR

I HEREBY AUTHORIZE SNELGROVE CHIROPRACTIC AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGTHER AS THEY DEEM NECESSARY. I CLEARLY UNDERSTAND THEAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

SIGNED: _____ DATE: _____