New Pediatric Information

Personal Information

Name: ________________________________ Home # ___________________ Parents Cell # __________________

Address____ Postal Code:________________

Birth date: month______ day ______ year ______ Age ______ Sex: M / F

How did you hear about us? ____________________________

Email Address_______________________________________ **Alberta Health Care** # _____________________________

Present Medical Doctor and address: ____

Date of last MD visit and reason: ____

Present length/height: _______________________________ Present weight: _____________________________________

Emergency Contact Name: __________________________ Emergency Contact Number: __________________________

Patient History

Chief Health Concerns: ____
____

Reason for contacting us: ____
____

List other care undergone for this complaint (including medications): ____
____

Date of onset: _______(yr)/_______(m)/_______(d) Onset was: Sudden / Gradual / Associated with an Event

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

Initiating factors: _________________________________ Aggravating factors: ____________________________________

Relieving factors: ___________________________ Prior occurrence or episodes: __________________________________

Effects of problems on body function and daily activities: ____
____

Hospital / Birthing Centre / Home / Medical / Midwife Duration of Gestation: _________________weeks

Assisted birth: No / Yes If yes: forceps / vacuum extraction / c-section / induced labour

Medications delivered to mother at birth? No / Yes If yes, what? ____

Duration of birth:_____ Complications at birth: No / Yes If yes, explain:____

Was delivery normal? Yes / No: ____

Do sleeping patterns seem normal to you: Yes / No Explain: ____

Any health problems (cancer, diabetes, heart disease etc.)______ On the mother's side of the family? _________________

On the father's? _________________________ With Siblings? ____

Since problems that Chiropractors concern themselves with can be related to many types of stressors, the following are also very important to us:

Was (is) this baby breast-fed? No / Yes For how long: ____

Formula introduced at what age? __________________ Type of formula used: _____________________________________

Introduction of cow's milk at age:_________ Began solid foods at age:_________ Type:_____________________________

Age & type of commercial baby food introduction: ____

Food / Juice intolerance: No / Yes Type:____

During pregnancy did the mother: Smoke? – Yes / No Drink alcohol? – Yes / No

Any illness of the mother during pregnancy? ____

Any supplements taken during pregnancy? ____

Is your child currently taking any supplements? ____

Any drugs taken during pregnancy? ____

Any exposures to ultrasound? No / Yes If so, how many and for what medical reason? ___________________________

Any invasive procedures (amniocentesis, CVS)? ____

Any pets at home: No / Yes Any smokers in the home? No / Yes How much? _________________________

Any vaccinations? No / Yes Which ones and any reactions____

Any antibiotics: No / Yes – Explain ______________________________Total # courses of antibiotics to date___________

Any difficulties with lactation? No / Yes:____

Any problems with bonding? No / Yes:____

Any behavioral problems? No / Yes – Onset: ____

Any night terrors, sleep walking, difficulty sleeping? No / Yes – Specify: ____

Age of child when began daycare:_______________ Average number of television hours per week: ____________________

Does your child seem normal for their age? Yes / No – Explain: ____

Any traumas during pregnancy (falls, accidents)? ____

Any evidence of birth trauma? – bruises/odd shaped head/stuck in birth canal/ fast or excessively long birth/ respiratory depression/ cord around neck/ other? ____

Any falls from couches, beds, change tables: No / Yes, Any traumas with bruising, cuts, stitches, fractures? No / Yes

Any hospitalizations? No / Yes – Explain: ____

Any surgeries or organs removed? ____

Sports played and age began:________________________________ Hours per week played: ________________

Weight of school backpack: ____Hours per week at play: ________________

Thank you for choosing our Chiropractic office.
We are looking forward to helping you be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Parent(s) Name(s): ____

Address If different from Child's): ____

Home phone (If different from Child's):___________________________ Work phone: _________________________________

I hereby authorize and consent to the Doctors of this clinic and their designated representatives to provide necessary Chiropractic Care including Health History Consultations, Treatments, X-rays, and/or other Procedures. I confirm that I am the custodial parent who has the legal authority to consent to the above.

____ X____

Patients Name (Please Print) Signature (Legal Guardian)

____ ____

Dr.'s Signature Date