Pediatric New Patient Information

Dear Parent:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help your child. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unware of. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your case.

Personal History

Child's Name: _____ Mom's Name: _____ Father's: _____

Date: _____ Health Ins. No.: _____ Phone: Home _____

Address: _____ Postal Code: _____

Age: _____ Weight: _____ Height: _____

Birth Date: _____ Birth Place: _____

School / Daycare: _____ Family MD / Pediatrician: _____

Referred to this office by: _____

Who is responsible for payment? ❑ Parent ❑ Guardian ❑ Other: _____

Insurance other than Alberta Health Care (London Life, Blue Cross, etc.): _____

Current Health Condition

Present complaint: _____

Previous treatment for this condition: _____

When did this condition begin? _____

Are there others in your family with the same condition? / or spinal conditions? _____

What do you believe caused this condition? _____

Presently taking medication? (please mention) _____

Past Health History

Birth History

Length of pregnancy: ❑ Full Term ❑ Early _____ ❑ Late _____

Problems during pregnancy (blood pressure, baby position): _____

Location of birth: ❑ Home ❑ Hospital ❑ Birthing Centre

Type of birth / delivery: ❑ Normal Vaginal ❑ Breech ❑ Caesarian

Invasive procedures: ❑ Epidural ❑ Forceps ❑ Vacuum

Length of labour: _____ ❑ Normal ❑ Difficult

Name of obstetrician / midwife: _____

Birth weight: _____ Birth length: _____

Presence of birth of ❑ Jaundice (yellow skin colour) ❑ cyanosis (blue colour)

APGAR scores: _____

Congenital anomalies / defects: _____

Infancy History

Feeding: ❑ Breast ❑ Bottle ❑ Formula

Latching well: ❑ Yes ❑ No

Breast preference: ❑ Yes ❑ No ❑ Left ❑ Right

Number of hours of sleep each night: _____

Quantity of sleep: ❑ Good ❑ Fair ❑ Poor

GENERAL PAST HISTORY

Falls or injuries: _____

Surgeries / Stitches / X-rays: _____

Treatment for any health condition in the past year: ❑ Yes ❑ No If yes, explain: _____

Previous chiropractic care and approximate date of last visit: _____

Vaccination history: _____

Reaction to vaccinations: _____

Last pediatrician appointment: _____

Please check any of the following conditions that are a problem and underline any there were a problem in the past.

Muscle & Joint
- ❑ sore muscles
- ❑ sore joints
- ❑ growing pains
- ❑ muscle cramps
- ❑ muscle jerking
- ❑ back problems
- ❑ neck problems
- ❑ painful tailbone
- ❑ pain between shoulders
- ❑ spinal curvature
- ❑ arthritis
- ❑ difficulty chewing / clicking jaw
- ❑ general stiffness
- ❑ walking problems
- ❑ feet turn in / out
- ❑ coordination problems
- ❑ headaches

General
- ❑ fatigue
- ❑ allergies
- ❑ difficulty sleeping
- ❑ dizziness
- ❑ fainting
- ❑ earaches / infections
- ❑ nose bleeds
- ❑ sore throat
- ❑ asthma
- ❑ chronic cough
- ❑ enlarged glands
- ❑ loss of weight
- ❑ poor / excessive appetite
- ❑ junk food
- ❑ nervousness
- ❑ depression / confusion
- ❑ vision problems
- ❑ dental problems
- ❑ hearing problems
- ❑ hyperactivity
- ❑ behavioral problems
- ❑ frequent colds / flu
- ❑ epilepsy
- ❑ rheumatic fever
- ❑ stomach aches
- ❑ hernias
- ❑ colic
- ❑ extreme fussiness
- ❑ screaming / crying
- ❑ night terrors
- ❑ tilting head to one side
- ❑ preferred side nursing
- ❑ difficulty nursing
- ❑ slow weight gain
- ❑ fussing when placed in specific positions
- ❑ lack of full head / neck movement
- ❑ seizures

Organs
- ❑ bedwetting
- ❑ constipation / diarrhea
- ❑ anemia
- ❑ thyroid
- ❑ vomiting
- ❑ skin eruptions / eczema
- ❑ colic

I have custodial rights for this child and by signing below authorize chiropractic care for him/her.

Signature: _____ Date: _____