Family Chiropractic & Massage Therapy
advance

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Family Chiropractor

PAEDIATRIC PATIENT INTRODUCTION

PATIENT INFORMATION

Patient Name:____
(First) (Middle) (Last)

Mother's Name: ______________________________ Father's Name: _______________________________
(First) (Last) (First) (Last)

Date of Birth: ______________________________ Gender: __________ Siblings (#):_______________
(Day/Month/Year)

Address: __________________________________ City: ________________ Postal Code: ____________

Home Phone: ______________ Mom's Work Phone: ______________ Dad's Work Phone:______________

Home e-mail: ____

Doctor's Name and Phone #: ____

Whom can we thank for this referral? ____

REASON FOR VISIT

Wellness Check _______ Specific Concern (please describe):____________________________________

BIRTH INFORMATION

Problems During Pregnancy: ____

Illness(es)/Medication During Pregnancy: ____

Ultrasound During Pregnancy? Yes/No How many?: ______________

Please describe this child's labour/delivery: ____
____
____

Location of Birth: Home: ____________ Birthing Centre: _____________ Hospital: ________________

Birth Type: Normal Vaginal: _______ Chemically Induced: ________ Premature: __________
Forceps: ________ Vacuum: ________ C-section: _________ Breech: _________

Birth Weight: _________________________________ Current Weight: _________________________
Birth Length: _________________________________ Current Length: __________________________

Apgar Scores: __________ Was there presence at birth of: Jaundice (Yellow): _____________
Cyanosis (Blue): _____________

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EARLY CHILDHOOD

At what age did this child: respond to sound? _______ follow an object with his/her eyes? ___________
hold his/her head up? ___________ sit alone? ____________ crawl? ___________
stand? ________ walk alone? _______ speak? ___________

Did you breastfeed? Yes/No If yes, how long?: _____ Did you formula feed? Yes/No If yes, how long?:_____

At what age did you introduce: Solids _______ Cow's milk ________

Are you aware of any food allergies or intolerances? ____

GENERAL HEALTH HISTORY

Has your child been hospitalized or had surgery? (e.g. accidents, illnesses, tonsillectomy, tubes in the ears, etc.)
____
____

Has your child been prescribed medication? When? __________________ What for? _____________________
____

Has your child suffered any physical trauma? (e.g. falls from change tables or down stairs, car accidents, sports injuries, etc.) ____
____

Please circle any condition that has affected your child in the past or that is currently an issue:

Colic	Diarrhea	Constipation	Gastroesophageal Reflux
Ear infections	Bed Wetting	Sleep Difficulties	Torticollis/Wry Neck
Frequent Coughs/Colds	Learning Difficulties	Hyperactivity	Growing Pains
Irregular/Painful Periods	Allergies	Headaches	Neck Pain
Back Pain	Digestive Trouble	Asthma	Leg/Arm Pain

FAMILY HEALTH HISTORY

Cancer	Stroke	Diabetes	Heart Disease
Arthritis	Thalassemia	Sickle Cell Disease	Connective Tissue Disorder

Other: ____

Thank you for taking the time to complete this questionnaire. The answers you have provided will help me to better understand your child's state of health and determine the most effective course of care.