Child Patient History for Chiropractic Care

Name:_____ Date:_____

Address:_____ City:_____

Province:_____ Postal Code:_____

Parent Name:_____ Phone Number:_____

Parent e-mail:_____ Work Number:_____

Referred by:_____ Cell Phone:_____

Health Card Number:_____ Birth Date:_____

What is your reason for consulting our clinic?_____

Was there any intervention in their birth? ☐No ☐Yes ☐C-section ☐Vacuum extraction ☐Forceps ☐Induction

Describe:_____

_____

Has your child ever been immunized? ☐No ☐Yes List any adverse effects: _____

Has your child had previous chiropractic care? ☐No ☐Yes By whom? _____ When? _____

For what condition?_____

Has your child had any falls or accidents? ☐No ☐Yes Describe:_____

_____

Has your child ever been hospitalized? ☐No ☐Yes When?_____ Why?_____

_____

Does your child sleep well? ☐No ☐Yes In what position? ☐Side ☐Back ☐Stomach

Is your child physically active? ☐No ☐Yes
Describe:_____

Has your child taken any of these drugs? ☐No ☐Yes ☐Pain killers ☐Muscle relaxants ☐Corticosteroids ☐Antibiotics ☐Inhalers ☐Mood altering (ritalin etc.) ☐Other_____

Any other health problems or
concerns?_____

_____

Please underline any conditions of concern:

NEUROLOGICAL	GASTROINTESTINAL	MUSCULAR	RESPIRATORY
Visual disturbances	Vomiting	Limping gait	Ongoing cough
Co-ordination difficulties	Diarrhea	Arched posture	Repeated colds
Excessive crying	Constipation	Uneven movement	Ear infections
Difficulty swallowing	Excessive gas	Complaints of pain	Headaches