Summerside Chiropractic Intake Form



New Patient I	nformation		*Email will be used for	
Name:		Email*:	Apt reminders & quarterly clinic info	
Phone #:		Alberta Health Care #		
Address:		Date of Birth:	Sex: Male Female	
City/Postal Code:		Status: Married Single	Child # of Children:	
Motor Vehicle Accident: Yes No Name of Partner: Worker's Compensation Board: Yes No				
Referred by:		Insurance: Yes No		
Occupation:		Previous Chiropractor:		
Physician:		Approx. Date of last Visit:		
Emergency Contac	t:	Reason for Previous Visit:		
Emergency #:		Other:		
and exer	Care (A proactive approach to health that moise.) What is your concern(s):			
	How long have you/ your child had these			
	Have you had this similar symptoms in the What activities aggravate you/child's symp			
	Are these symptoms getting progressively Are these symptoms Interfering with your How long has it been since you really felt g Others professionals who have treated this Result with treatment? In the past 5 years, have x-rays been taken	Work/School Sleep Daily good?s condition?		
Adult & Child	: Are you currently on a program of: a) vitamins b) minerals c) herbs c What is your estimation of your present g Are you frequently Ill? Y N Do you often feel exhausted? Y N Do you have trouble sleeping? Y N Are you worried about receiving chiroprae	eneral Health: Excellent Good	dFairPoor	

Child 0-6 yrs Health History

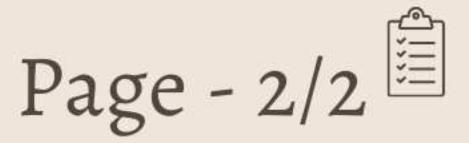
Any antibiotics given? If yes, Reason?_____



Child's Name:	Age:	Family Physician:				
Parent/Guardian Name:		Approx. Date of Last Visit:				
Present Weight:	Height:	Reason for Visit: Check Up D Other:				
Check a	ny of the following conditions you	r child has suffered during tl	ne past six months:			
☐ Ear Infection	Seizures	Chronic colds	Headaches			
Asthma	Digestive problems	ADHD	Reoccurring fever			
Colic	Growing pains	☐ Back pains	☐ Bed wetting			
Allergies:	Car Accident	Tempertantrums	Other:			
Family History: Please note any	health problems (eg. cancer herec	litary conditions, heart diseas	se etc.) that are present in:			
Mother's Family:						
Father's Family:						
Sibling(s):						
History of Birth:						
Duration of Gestation: Indicate W	H.4. 54. 55.0 55.0 55.0 55.0 55.0 55.0 55					
Was labour spontaneous or induc	*					
Was Childs birth at Home, Birthir	ng Centre or Hospital? acuum, Extraction, C-Section, Episi	otomi				
Duration of Labour and Birth? (ho	70 (V) 1010 (B)	otomy				
27	rst) or Breech (feet first)?	•				
Were there any complications? If						
Were medications or epidurals gi	iven to the mother during the birth?	If yes, what was given				
AGPAR score at birth? Birth/	10 & After 5 Minutes/10					
Birth Weight and Length?						
Growth and Development:						
At what age did the child:	Do Sleeping patterns seem No	rmal?				
Respond to sound	If No, please explain:					
Follow an object						
Hold head up Vocalize						
Sit Alone						
Teethe						
Vaccination History:						
Vaccinations and age given?						
Any negative reactions? If yes, what were they?						

Child 0-6 yrs Health History





Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

5	Physical Stressors :
_	Any traumas to the mother during Pregnancy? (eg. Falls, accidents etc) If yes, please explain:
	Any evidence of birth Trauma to the infant? Bruising, stuck in birth canal, cord around neck, odd shaped head, respiratory
	depression, fast or excessively long birth. etc Please list:
_	Any falls from couches, beds, change tables? If yes, please explain:
	Any traumas resulting in bruises, cuts, stitches, or fractures? If yes, please explain:
	Any hospitalizations or surgeries? If yes, please explain:
Ц	Any Sports Played? List all:
Ш	Is a school backpack used? If yes, Heavy or Light?
	Chemical Stressors :
	Was Child breastfed? if yes, how long:
	Formula introduced at what Age? & What Formula?
	Introduction of cow's milk at what age?
	Began solid foods at what age? & Type of foods?
	Food / Juice Intolerance? If yes, what type?
	During pregnancy did mom smoke? If yes, how much?
	During pregnancy did mom drink? If yes, how much?
	Any illnesses during pregnancy? If yes, what illnesses?
	Any supplements taken during pregnancy? If yes, what supplements?
	Any drugs taken during pregnancy? If yes, what drugs?
	Any Ultrasounds? If yes, how many and reasons for being done?
	Any invasive procedures during pregnancy (eg. Amniocentesis, CVS etc.) If yes, please explain
	Any pets at home? If yes, what kind(s)?
	Any smokers in the home?
	Psychosocial Stressors :
	Any difficulties with lactation? If yes, what are they?
	Any difficulties with bonding? If yes, what are they?
	Any behavioural problems? If yes, what are they?
	Any night terrors, sleep walking, difficulty sleeping? Please list:
	Age of Child when he/she began daycare?
	Average number of hours of screen time per week?
	Do you feel that your child's social and emotional development is normal for their age? If no, why?
	If there are any other questions or concerns which you have, you may write them below.

Authorization for Care of a Minor (Under 18 yrs)

I hereby authorize and consent to the Chiropractic evaluation and care of my Child

Parent name	Parent Signature	Child Name	Date
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