Summerside Chiropractic
Intake Form

Date __/__/____

New Patient Information

Name:

Phone #:

Address:

City/Postal Code:

Name of Partner:

Referred by:

Occupation:

Physician:

Emergency Contact:

Emergency #:

Email*:

*Email will be used for Apt reminders & quarterly clinic info

Alberta Health Care #

Date of Birth: Sex: Male ☐ Female ☐

Status: Married ☐ Single ☐ Child ☐ # of Children:

Motor Vehicle Accident: Yes ☐ No ☐

Worker's Compensation Board: Yes ☐ No ☐

Insurance: Yes ☐ No ☐ If Yes, Insurer:

Previous Chiropractor:

Approx. Date of last Visit:

Reason for Previous Visit: Check Up ☐

Other:

We offer different types of care.

Check more than one box if applicable so that we may be guided by your wishes.

- ☐ Spinal/Health check up
- ☐ Pain Relief
- ☐ Corrective Care (prevents re-occurance of pain by addressing the underlying cause)
- ☐ Wellness Care (A proactive approach to health that maximizes your health potential by optimizing nerve function, diet and exercise.)

Adult & Child:

What is your concern(s): _____

How long have you/ your child had these symptoms: _____

Have you had this similar symptoms in the past? _____

What activities aggravate you/child's symptoms? _____

Are these symptoms getting progressively worse? Y__ N__ Constant__ Comes and Goes __

Are these symptoms Interfering with your Work/School__ Sleep__ Daily Routine__ Eating __ Other? _____

How long has it been since you really felt good? _____

Others professionals who have treated this condition? _____

Result with treatment? _____

In the past 5 years, have x-rays been taken? Y__ N__ If Yes, Where? _____

Adult & Child:

Are you currently on a program of: _____

a) vitamins__ b) minerals__ c) herbs__ d) diet__ e) exercise__ f) other _____

What is your estimation of your present general Health: Excellent __ Good__ Fair__ Poor__

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 chiropractic care? Y__ N__

Child 7-12 yrs Health History

Child's Name: Age:

Parent/Guardian Name:

Family Physician:

Approx. Date of Last Visit:

Reason for Visit: Check Up ☐ Other:

Below are a list of symptoms which may seem unrelated to the purpose of your appointment. These questions must be answered carefully as these problems can effect your overall course of chiropractic care.

- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Loss of taste
- ☐ Numbness in Feet
- ☐ Headaches
- ☐ Dizziness
- ☐ Weight Gain
- ☐ Fainting
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Heart Palpitations
- ☐ Irritability
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Reduced Mobility
- ☐ Loss of Balance
- ☐ Fevers
- ☐ Fainting
- ☐ Light Sensitivity
- ☐ Dental Problems
- ☐ Loss of Concentration
- ☐ Heartburn
- ☐ Chest Pressure
- ☐ Constipation
- ☐ Loss of Smell
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Sore Throat
- ☐ Sinus Congestion
- ☐ Ears Buzzing
- ☐ Ear Pain/Infections
- ☐ Poor Coordination
- ☐ Muscle Cramps
- ☐ Weight Loss
- ☐ Stiffness
- ☐ Depression
- ☐ Numbness in Hands
- ☐ Sleeping Problems
- ☐ Urinary Problems
- ☐ Diarrhea
- ☐ Bloating / Gas
- ☐ Frequent Colds
- ☐ Numbness in Leg(s)
- ☐ Asthma
- ☐ Weakness
- ☐ Vision Changes
- ☐ Allergies _____

Family History: Please note any health problems (eg. cancer hereditary conditions, heart disease etc.) that are present in:

Mother's Family: _____

Father's Family: _____

Sibling(s): _____

History of Birth:

Duration of Gestation: Indicate Weeks? _____

Was labour spontaneous or induced? _____

Was Childs birth at Home, Birthing Centre or Hospital? _____

Assisted Birth? If yes: Forceps, Vacuum, Extraction, C-Section, Episiotomy _____

Duration of Labour and Birth? (hours) _____

Was child born Cephalic (head first) or Breech (feet first)? _____

Were there any complications? If yes, please explain: _____

Were medications or epidurals given 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? _____

Vaccination History:

Vaccinations and age given? _____

Any negative reactions? If yes, what were they? _____

Any antibiotics given? If yes, Reason? _____

Child 7-12 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.

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: _____
- ☐ Any Sports Played? List all: _____
- ☐ 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 _____