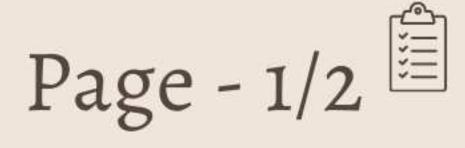
Summerside Chiropractic Intake Form



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	e Child # of Children:	
Name of Partner:		Motor Vehicle Accident: Yes No No Worker's Compensation Board: Yes No		
Referred by:		Insurance: Yes No If Yes, Insurer:		
Occupation:		Previous Chiropractor:		
Physician:		Approx. Date of last Visit	:	
Emergency Contac	t:	Reason for Previous Visit: Check Up		
Emergency #:		Other:		
Adult & Child:	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 symptoms			
	Are these symptoms getting progressively Are these symptoms Interfering with your How long has it been since you really felt Others professionals who have treated the Result with treatment? In the past 5 years, have x-rays been taken	r Work/School Sleep Daily good? is condition?		
Adult & Child	: Are you currently on a program of: a) vitamins b) minerals c) herbs What is your estimation of your present go Are you frequently Ill? Y N Do you often feel exhausted? Y N Do you have trouble sleeping? Y N	general Health: Excellent Goo		

Child 7-12 yrs Health History



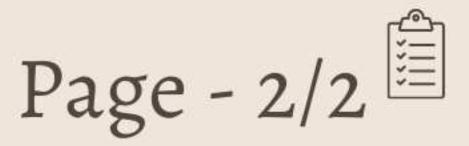


Child's Name:	Age:	Family Physician:	
Parent/Guardian Name:		Approx. Date of Last Visit:	
Reason for Visit: Check Up Other:			
	which may seem unrelated to the purully as these problems can effect yo		
 □ Neck Pain □ Upper Back Pain □ Low Back Pain □ Loss of taste □ Numbness in Feet □ Headaches □ Dizziness □ Weight Gain □ Fainting □ Shortness of Breath □ Difficulty Breathing 	☐ 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	 □ Depression □ Numbness in Hands □ Sleeping Problems □ Urinary Problems □ Diarrhea □ Bloating / Gas □ Frequent Colds □ Numbness in Leg(s) □ Asthma □ Weakness □ Vision Changes
Heart Palpitations Family History: Please note a Mother's Family:	ny health problems (eg. cancer here	Stiffness editary conditions, heart diseas	Allergiesse etc.) that are present in:
Father's Family: Sibling(s):			
History of Birth:			
Was labour spontaneous or income Was Childs birth at Home, Birth Assisted Birth? If yes: Forceps Duration of Labour and Birth? Was child born Cephalic (head Were there any complications? Were medications or epidurals AGPAR score at birth? Birth Birth Weight and Length?	first) or Breech (feet first)?	siotomy	
Vaccination History:			
Any negative reactions? If yes,	SAME CARE CANCEL THE BACK OF SECTION OF SEC		

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