New Pediatric Information

Name:_____ Hm # _____ Parents Cell # _____

Address_____Postal Code:_____

Birth date: month_____ day_____ year_____ Age_____ Sex: ☐ M / ☐ F

Email Address_____ **Sask Health Care** # _____

Present Medical Doctor and address:_____

Date of last MD visit and reason:_____

Present length/height:_____ Present weight:_____ _____

Patient History

Chief Health Concerns:_____

_____

Reason for contacting us:_____

_____

List other care undergone for this complaint (including medications):_____ _____

_____

Date of onset: _____(yr)/_____(m)/_____(d) Onset was: ☐Sudden / ☐Gradual / ☐ Associated with an Event

Duration of problem (episode): ___ minutes / ___ hours / ___ days / ____ months / ____ years

Initiating factors:_____ Aggravating factors:_____

Relieving factors:_____ Prior occurrence or episodes:_____ _____

Effects of problems on body function and daily activities:_____

_____

☐ Hospital / ☐ Birthing Centre / ☐ Home / ☐ Medical / ☐ Midwife Duration of Gestation_:_____weeks

Assisted birth: ☐ No / ☐ Yes If yes: ☐ forceps / ☐ vacuum extraction / ☐ c-section / ☐ induced labour

Medications delivered to mother at birth? ☐ No / ☐ Yes If yes, what?:_____

Duration of birth:_____ Complications at birth: ☐ No / ☐ Yes If yes, explain:_____

Was delivery normal?: ☐ Yes / ☐ No:_____ ___

Do sleeping patterns seem normal to you: ☐ Yes / ☐ No Explain:_____

Any health problems (cancer, diabetes, heart disease etc.)_ On the mother's side of the family?:_____

On the father's?:_____ With Siblings?:_____

Since problems that Chiropractors concern themselves with can be related to many types of stressors, the following is also very important to us:

Was (is) this baby breast-fed?: ☐ No / ☐ Yes For how long:_____

Formula introduced at what age?:_____ Type of formula used:_____

Introduction of cow's milk at age:_____ Began solid foods at age:_____ Type:_____

Age & type of commercial baby food introduction:_____

Food / Juice intolerance: ☐ No / ☐ Yes Type:_____

During pregnancy did the mother: Smoke? – ☐ Yes / ☐ No Drink alcohol? – ☐ Yes / ☐ No

Any illness of the mother during pregnancy?:_____

Any supplements taken during pregnancy?:_____

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Any drugs taken during pregnancy?:_____

Any exposures to ultrasound?: ☐ No / ☐ Yes If so, how many and for what medical reason?_____

Any invasive procedures (amniocentesis, CVS)?:_____

Any pets at home: ☐ No / ☐ Yes Any smokers in the home?: ☐ No / ☐ Yes How much?_____

Any vaccinations?: ☐ No / ☐ Yes Which ones and any reactions_____

Any antibiotics: ☐ No / ☐Yes, Explain:_____ Total # of courses of antibiotics to date: ___

Any difficulties with lactation?: ☐No / ☐Yes:_____ Any problems with bonding?: ☐No / ☐Yes:_____

Any behavioral problems?: ☐No / ☐Yes – Onset:____

Any night terrors, sleep walking, difficulty sleeping?: ☐No / ☐Yes – Specify:_____

Age of child when began daycare:_____ Average number of television hours per week:_____

Does your child seem normal for their age?: ☐Yes / ☐No – Explain:_____

Any traumas during pregnancy (falls, accidents)?:_____

Any evidence of birth trauma? – ☐ bruises, ☐odd shaped head, ☐stuck in birth canal, ☐fast or ☐ excessively long birth, ☐respiratory depression, ☐ cord around neck, other?:_____

Any falls from couches, beds, change tables: ☐No / ☐Yes Any traumas with bruising, cuts, stitches, fractures?: ☐No / ☐Yes

Any hospitalizations?: ☐No / ☐Yes – Explain:_____

Any surgeries or organs removed?:_____

Sports played and age began:_____ Hours per week played:_____

Weight of school backpack:_____ Hours per week at play:_____

Thank you for choosing our Chiropractic office.

We are looking forward to helping you be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Parent(s) Name(s):_____

Address (If different from Child's):_____

Home phone (If different from Child's):_____ Work phone:_____

I hereby authorize and consent to the Doctors of this clinic and their designated representatives to provide necessary Chiropractic Care including Health History Consultations, Treatments, X-rays, and/or other Procedures. I confirm that I am the custodial parent who has the legal authority to consent to the above.

_____ _____

Patients Name (Please Print) Signature (Legal Guardian)

_____ _____

Dr.'s Signature Date

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