FOOTHILLS FAMILY CHIROPRACTIC

CHIROPRACTIC NEW PATIENT
CHILD (< 10) HEALTH HISTORY INTAKE

Full Name: _____ **Date of Birth:** _____

Parent/Guardian Full Name(s): _____

Child Gender: _____ Height: _____ Weight: _____

Who referred your child to the clinic?_____

Family Doctor: _____ Paediatrician: _____

Current condition:

Main concern that brings you into the office: _____

When did this concern begin? _____

Other Practitioners seen for this concern: _____

Has your child had this condition before? YES / NO

If yes, please explain: _____

Health History (Please circle all that apply)

Location of Birth: HOSPITAL / HOME / OTHER:_____

Birth Intervention: FORCEPS / VACUUM EXTRACTION / CESARIAN SECTION

Complications during Delivery? YES / NO DESCRIBE:_____

Genetic disorders or disabilities? YES / NO DESCRIBE:_____

Are you concerned about your child not meeting developmental milestones? If yes, describe:

_____

Food Allergies or Intolerances? YES / NO Describe:_____

Does your child have a normal sleep pattern? YES / NO Describe:_____

Does your child have normal bowel movements? YES / NO
Describe:_____

Has your child had any major falls/injuries/accidents, broken bones or surgeries? YES / NO

Describe:_____

Has your child ever been involved in a motor vehicle accident? YES / NO

Describe:_____

Please describe your child's current sports activities:_____

Please list prescribed or over-the-counter medication child is taking (names, frequency of use and condition taken for):

_____

Is your child currently taking any herbs, nutritional supplements, or natural remedies? Describe:

_____

Daily water intake (cups): _____ *(if applicable)*

Please indicate and family history conditions (ex. Cancer, diabetes, heart attack, stroke, connective tissue disorders, arthritis, spinal conditions).

Father: _____

Mother:_____

Brother(s): _____

Sister(s): _____

Has your child ever received spinal adjustments by a Doctor of Chiropractic? YES / NO

Doctor's Name:_____ Date of Last Visit: _____

Reason for change/interruption of care: _____

Any additional information you would like to provide?

_____

_____

_____

_____

_____

Please check (✓) any conditions that have occurred in the past 6 months. Please underline any symptoms that were a problem in the past 2 years.

	Headache		Frequent colds / flu		Preferred side for nursing
	Migraine		Seizures		Difficulty nursing
	Lack of head/neck motion		Epilepsy		Latching issues
	Nose bleeds		Fatigue		Difficulty chewing
	Recurrent ear infections		Fainting		Clicking jaw
	Sore throat		Anemia		Muscle cramps
	Chronic cough		Thyroid issues		Neck problems
	Enlarged glands/ lymph nodes		Depression		Back problems
	Dizziness		Nervousness		Growing pains
	Loss of hearing		Extreme fussiness		Sore muscles
	Loss of balance		Recurrent stomach aches		Sore joints
	Loss of taste		Loss of weight		Generalized stiffness
	Complaints of neck pain		Poor appetite		Feet turning In / Out
	Pain between shoulders		Poor Digestion		Lower limb pain
	Head turns to one side (LEFT / RIGHT)		Constipation		Coordination problems
	Head shape concerns		Diarrhea		Toe-Walking
	Fussiness in certain positions		Hernias		Asthma
	Spinal curvature / scoliosis		Colic		Allergies
	Low back pain (LEFT / RIGHT)		Reflux		Skin eruptions
	Mid-back pain (LEFT / RIGHT)		Bed wetting		Eczema
	Tailbone pain		Hyperactivity		
			Behavioural problems		