NORFOLK CHIROPRACTIC WELLNESS CENTRE

Chiropractic Pediatric Intake Form

Please complete this questionnaire. Your answers will help us in the complete assessment of your child's spinal health.

Child's Name: _____ **Initial Visit Date**: _____

Birthdate: _____ Sex: M / F Ht: _____ Wt: _____ Family Doctor: _____

Please list any medications child is currently taking: _____

Contact Information: *(please check off primary contact person and preferred method(s) of contact)*

☐ Mother's Name: _____ ☐ Father's Name: _____

☐ Home phone #: _____

☐ Cell phone #: _____

☐ Work phone #: _____

☐ Email Address: _____

Secondary Contact (Name & Phone #): _____

If more than one residence, please check off which address should be listed for receipts:

☐ Address 1: _____ City: _____ Postal Code: _____

☐ Address 2: _____ City: _____ Postal Code: _____

How did you hear about us?

☐ Yellow pgs ☐ Internet ☐ Referral: _____ ☐ Other: _____

Family Medical History:

Has anyone in your family had any of the following diseases/conditions?

☐ Hypertension	☐ Heart Disease	☐ Lung Disease	☐ Cancer – type: _____
☐ Stroke	☐ Tuberculosis	☐ Epilepsy	☐ Diabetes
☐ Alzheimer's Disease	☐ Scoliosis	☐ Osteoarthritis	☐ Ankylosing Spondylitis
☐ Multiple Sclerosis	☐ Osteoporosis	☐ Gout	☐ Rheumatoid Arthritis
☐ Psoriasis	☐ Scoliosis	☐ Low Back Pain	☐ Disc Disease
☐ Migraine Headaches	☐ Scarlet Fever	☐ Polio	☐ Diphtheria
☐ Shingles	☐ Alcoholism	☐ Malaria	☐ Anemia

☐ Other (specify): _____

_____

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Pediatric Health Questionnaire

Please complete this questionnaire. Your answers will help us in the complete assessment of your child's spinal health.

Child's Name: _____ Age: _____ years old

Purpose of this office visit: □ Spinal Check up □ Other(please specify): _____

Please Tell Us About:

Pregnancy - Please check off any applicable conditions/issues:

□ Toxemia □ Diabetes □ Pre-Eclampsia □ Hypertension □ Water Retention

□ Allergies □ Food Sensitivities □ Nausea/Vomiting □ Heartburn □ Back pain

□ Other: _____

Delivery/Neonatal Life

Was child Full-term? □ Yes □ No - # weeks early _____ # weeks late _____ How long was labour? _____ hrs

Were you induced? □ Yes □ No How? □ Vaginal □ Intravenous Any medication used? _____

Please check off all the following that apply:

□ Episiotomy □ Epidural □ Vaginal delivery □ C-section □ Forceps □ Vacuum Extraction

□ Anoxia □ Jaundice □ Blood Transfusions □ Other complications (specify): _____

Infancy/Childhood

What position does your child sleep in? □ Side □ Back □ Front Has child ever had a postural analysis? □ Yes □ No

Has your child ever been suspected of having/diagnosed with any of the following:

□ Poor posture □ Scoliosis (spinal curvature) □ Kyphosis/Lordosis □ Hip dysplasia

□ Leg length inequality □ Flat feet □ Muscular torticollis

Has child ever been hospitalized? □ Yes □ No – Reason: _____

Has child ever had surgery? □ Yes □ No – Reason: _____

Has child ever experienced any of the following health problems?

□ Colic □ Allergies □ Bronchitis □ Pneumonia □ Recurrent colds/flu □ Food/drug reactions

□ Asthma □ Seizures □ Diabetes □ Ear infections □ Other (specify): _____

Has child had any of the following infectious childhood diseases?

□ Influenza □ Mumps □ Measles □ Rubella □ Poliomyelitis □ Chicken Pox □ Mononeucleosis

□ Tuberculosis □ Hepatitis □ Meningitis □ Other (specify): _____

Has child been immunized? □ Yes □ No Has child ever had an adverse reaction to vaccines? □ Yes □ No

Please describe reaction: _____

Has your child ever had any of the following?

□ Fracture/dislocation □ Concussion □ Whiplash □ Head trauma □ Sports injuries

Please describe: _____

Has child had any major falls? □ Yes □ No Describe: _____

Has child been involved in a car accident? □ Yes □ No Describe: _____

Has child had previous chiropractic care? □ Yes □ No Dr. _____ Reason: _____

Previous x-rays? □ Yes □ No Date: _____ Reason: _____

What is the frequency of child's bowel movements? _____ Consistency? _____

Does child experience discomfort or pain associated with bowel movements? □ Yes □ No