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 ☐ Mononucleosis
☐ 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