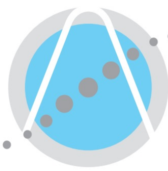

ACTIVE
CHIROPRACTIC & WELLNESS

PAEDIATRIC INTAKE FORM

Patient Information: Please fill in information as it appears on your Manitoba Health Card

Child's Name: ________________________ D.O.B: (dd/mm/yyyy)________________
Sex: ◻ Male ◻ Female Age: _______ Height: ___________ Weight: __________
P.H.I.N #: ____________________________ **6 Digit Medical #:** ___________________________
Name of Parents: ____
Address: ____________________________ City: ______________ Prov: ___________ Postal Code: ___________
Email: ____________________________________
Home Phone #: ______________________
Dad's Cell Phone #: ___________________ Mom's Cell Phone #: __________________
Reason(s) for seeking care: ____
Other Doctor(s) seen for this condition? (Circle) Yes / No
If yes, doctor name(s) and prior treatment. ____

OTHER HEALTH PROBLEMS

Please check any current or past problems your child has had on the list below:

__Dizziness	__Diabetes	__Anemia	__Broken Bones
__ADHD	__Tuberculosis	__Rheumatic Fever	__Sprains/Strains
__Autism	__Hypertension	__Poor Appetite	__Fainting
__Backaches	__Arthritis	__Hyperactivity	__Hernias
__Neck pain	__Heart Condition	__Behavioral	__Arm/Elbow Pain
__Headaches	__Rashes/Hives	__Poor Memory	__Leg/Hip Pain
__Allergies	__Digestive	__Insomnia	__Knee/Foot Pain
__Asthma	__Sinus Trouble	__Nightmares	__Growing Pains
__Runny Nose	__Neuritis	__Bed Wetting	__Joint Pain
__Itchy Eyes	__Cough/Wheeze	__Pain Urinating	__Scoliosis
__Chronic Ear Infections	__Chest Pain	__Convulsions	__Blood Disorders
__Frequent Colds	__Constipation	__Paralysis	__Stomach Aches
__Fever/Chills	__Diarrhea	__Muscle Pain	__Other

HEALTH HISTORY

Previous Chiropractor(s): _________________________ Reason for Care:_________________________
Name of Pediatrician: ____________________________ Date of last visit: ________________________
Reason for visit: ____
Number of antibiotics taken in lifetime:______ Condition(s) treated: ____________________________
Medications and conditions being treated: ____
Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc.)? Y/N
If yes, please describe with dates:____
Prior surgeries? Y/N Type and Date: ____
Vaccination History: ____

PRENATAL HISTORY

Childbirth caregiver(s): OB/GYN _________ Doula _______ Midwife ________

Location of birth: Hospital _______ Home _________ Birth Center _________

Medications used during birth: None _____ Ptocin _______ Epidural _______

Interventions used during birth: Breaking of water ____ Vacuum _____ Forceps ____ Episiotomy _____

Position of baby at birth: Head down _______ Posterior ________ Breech or malposistioned _________

How long was your labor? ____

Complications during pregnancy: Y/N If yes, Please describe____________________________________

Complications during delivery: Y/N If yes, Please describe: _____________________________________

Did you have chiropractic care during your pregnancy? Y/N

Cigarette/Alcohol use during pregnancy: Y/N

Ultrasound during pregnancy: Y/N

Cesarean: Y/N Planned ________ Emergency ____________

Genetic Disorder/Disability? Y/N If yes, Please describe: ______________________________________

Birth weight ___________________________________ Birth length _______________________________

APGAR scores ____

FEEDING HISTORY

Breast Fed: Y/N How long? ____

Formula Fed: Y/N How long? ____

Type of formula:____

Introduced to solids at __________________ months, Cow's milk at ______________________ months

Food/ juice allergies or intolerances: Y/N Please List: ____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night __________ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

Respond to sound ________ Follow object with eyes ________ Hold head up ________

Crawl ________ Sit alone ________ Stand alone _________

Walk alone _______ Say words _______

CHILDHOOD DISEASES

At what age (if ever) did your child suffer from the following:

Chicken Pox _______ Rubella _______ Measles ___________

Mumps _______ Whooping Cough _______ Other_________

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and it's Doctor(s) of Chiropractic to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am responsible for payment of all fees charged by this office.

_____________________________ _____________________________ __________________

Parent or Guardian (Print) Signature Date