Entrance Form – Child/Teen

Name: _____ Date: _____

Address: _____ City: _____

Postal Code: _____ Home Phone: _____

Work/Cell Phone: _____ Email: _____

Date of Birth: _____

Family Doctor: _____ City: _____

How did you hear about our clinic? _____

Purpose for contacting us: _____

Please circle any of the following conditions you have suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds
Asthma	Digestive Problems	ADHD	Recurring Fevers
Allergies	Bed Wetting	Car Accident	Headaches
Autism	Growing Pains	Back Pain	Other _____

Does this condition interfere with:
Sleeping? Yes No Daily Activities? Yes No Exercising? Yes No

When did you first notice this condition? _____

Were you ever knocked unconscious? Yes No Comments: _____

Have you ever broken any bones? Yes No Comments: _____

Previous Chiropractic Care: Yes No
Name of Chiropractor: _____ Last Visit: _____

Number antibiotics (doses) taken:
During the past six months: _____ Total during lifetime: _____

Number of doses and type of other prescription medications taken:
During the past six months: _____
Total during lifetime: _____

Vaccination History: _____

Are you involved in any high impact or contact sports (soccer, football, hockey, gymnastics, baseball, ballet, martial arts, etc)
Yes No List: _____

Have you ever been involved in a car accident? Yes No List: _____

Have you ever been seen on an emergency basis? Yes No List: _____

Have you ever been hospitalized? Yes No List: _____

Other trauma (falls, accidents, injuries) not described above? Yes No
List: _____

Prior Surgery? Yes No List: _____

Birth History:

Complications during pregnancy? Yes No List: _____

Medications during pregnancy/delivery? Yes No List: _____

Birth Interventions: Forceps ____ Vacuum Extraction _____
C-Section _____ Emergency/Planned _____ Complications during delivery? Yes No
List: _____

Genetic disorders or disabilities? Yes No List: _____

Have you had: spinal tap ___ spinal injections ____ physiotherapy ___ neck collar ___ spinal brace ___ heel lift ___ corrective shoes ___ chemotherapy ___ transfusion ___ naturopathy ___ homeopathy ____

Have you ever had x-rays? Yes No When: _____

I authorize Dr. Carla Day or her designate to examine my son/daughter as she deems necessary.

Signed: _____ Date: _____