KENASTON FAMILY CHIROPRACTIC

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Name_____ Date of Birth _____/_____/_____ Today's Date _____
MHSC REG #(6digit) _____ (As it appears on MHSC card)
Address _____City _____
Province _____ Postal Code_____ Phone (Home) _____
Mother_____
Father _____
Pediatrician/Family MD _____City & Prov. _____
Last Visit: ____/____/____
Purpose of last visit
_____
Birth Height: _____ Birth Weight: _____ Age: _____
Ever been under chiropractic care? _____

PREGNANCY HISTORY:
Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow
Type of Birth: _____Normal Vaginal _____Forceps _____Caesarean _____Suction Cap or Vacuum
Location: _____Home _____Hospital _____Birthing Center _____Other:_____
Problems during Pregnancy:
_____
Problems during Labor/Delivery:
_____
Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/Defects?
If yes, please explain: _____

INFANT HISTORY:
Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____
Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor
List all **IMMUNIZATIONS** you child has had:
_____
Has your child ever been treated at the emergency room? _____
If yes; please explain _____
Has your child ever been hospitalized? _____
If yes; please explain _____
Has your child ever had any Surgeries? _____
Is your child currently on any medication? _____
If yes; please list: _____

AT WHAT AGE DID THE CHILD:
Respond to sound_____ Follow an object with his/her eyes_____ Hold head up_____
Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

AT WHAT AGE, IF EVER, DID CHILD EXPERIENCE THE FOLLOWING?
Chicken pox_____ Mumps_____ Measles_____ Rubella_____
Whooping Cough_____ Other: _____

If Is your child currently on any medication? _____ If yes; please list:
_____

HAS YOUR CHILD EVER EXPERIENCED:

- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Seizures/ Convulsion
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backache
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Problems
- ☐ Poor Appetite
- ☐ Stomach Ache
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Sleeping Problems
- ☐ Behavioural Problems
- ☐ ADD/ADHD
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

HAS YOUR CHILD EVER EXPERIENCED THE FOLLOWING SPINAL TRAUMAS:

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from high chair
- ☐ Fall from changing table
- ☐ Fall from bed/couch
- ☐ Fall off swing
- ☐ Fall from slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard/ skates
- ☐ Fall from bicycle
- ☐ Fall down stairs
- ☐ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____
Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

FAMILY HISTORY:
Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:
____ Heart Disease ____ Diabetes ____ Stroke
____ Cancer ____ High / Low blood pressure ____ Asthma _____
Gastrointestinal disease ____ Memory/mood disorder ____ Thyroid problem

CHILD'S CURRENT PROBLEM:
Purpose of this visit: _____Wellness _____Check-up _____Other: _____
____Pain/Discomfort; explain_____
____Injury; explain_____
If due to Pain/Discomfort/Injury, please fill out:
1. Onset of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. Ever had this problem before? _____
3. Any bowel or bladder problems since this problem began? No ____Yes (Describe):_____
4. Any medication taken for this problem? No Yes: _____
5. Have you seen any other doctors for this problem? No Yes: _____
6. How is this problem **NOW**: Rapidly Improving _____Improving Slowly _____About the Same_____ Gradually Worsening_____ On & Off_____