

Children's Intake - Ages 5-12

E-mail: _____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail for appointment reminders and information regarding your wellness.

Do you consent? YES NO _____

Please sign name here



Welcome to Complete Health!

This form is to provide your doctor with a detailed health history to better manage your case. Please complete the form to the best of your knowledge.

Date: _____ Alberta Healthcare Number: _____

Child's Name: _____ Last Name: _____

Mother's Name: _____ Mother's Phone #: _____

Father's Name: _____ Father's Phone #: _____

DOB: _____ Age: _____ Male Female

Num. of siblings: _____ Child's Weight: _____ Child's Height: _____

Address: _____ City: _____ Postal Code: _____

Do you have Alberta Blue Cross/ASEB Blue Cross/Medavie Blue Cross? YES NO

ID# _____ Group# _____

How did you hear about Complete Health? _____

Have you ever seen a Chiropractor? YES NO

Who? _____ Date of last adjustment? _____

Pediatrician / Family Medical Doctor: _____

Date of last visit to Medical Doctor: _____ Purpose: _____

Vaccination history: _____

Childhood Diseases: Chickenpox Rubella Mumps Measles Whooping Cough

Other: _____

What operations have you had? When? _____

Have you ever been seen in Emergency? YES NO Why: _____

Have you ever been hospitalized? YES NO Why: _____

Have you ever had any bad accidents or falls? Yes No If so, when? _____

Broken/Fractured bones? Yes No Which ones? _____

Type of Birth: Normal Vaginal Forceps Cesarean Hospital: _____

Problems during pregnancy: _____

Problems during labor or delivery: _____

Length of labor: _____ Congenital abnormalities or defects: _____

Number of hours of sleep per night: _____ Quality of sleep: Good Fair Poor

Purpose of this appointment: _____

Explain how complaint occurred: _____

When did this condition begin? _____

Condition has persisted for: DAYS WEEKS MONTHS YEARS

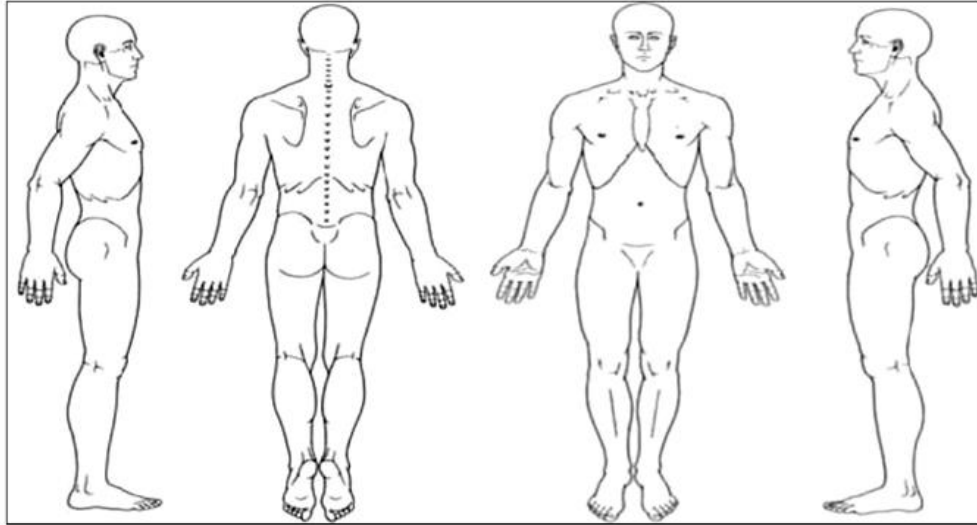
What activities make this condition better? _____

What activities make this condition worse? _____

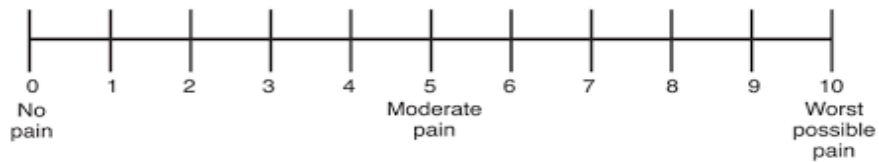
Have you seen anyone else for this condition? If so, whom? _____

Medications/supplements/vitamins you are taking: _____

DRAW YOUR PAIN- Mark in the areas on the diagrams where you have pain.



RATE YOUR PAIN ON THIS SCALE- Mark with an X



Health Systems Review Please check each of the following diseases or conditions that you have now or have had in the past

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Constipation | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Kidney infection or stone |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Nervousness / Depression | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Colds | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Chronic Ear Aches |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Deafness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tingling or numbness in: | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Aids / HIV positive |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Spitting | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Failing vision | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Psoriasis / Eczema |
| <input type="checkbox"/> Hands | | | |
| <input type="checkbox"/> Hips | | | |
| <input type="checkbox"/> Legs | | | |
| <input type="checkbox"/> Knees | | | |
| <input type="checkbox"/> Feet | | | |

AUTHORIZATION FOR CARE OF A MINOR

The Informed Consent must disclose, to the patient or the guardian of a minor patient, the nature of the proposed treatment or procedure and any potential risks including those that may be of a special or unusual nature.

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

Signed: _____ Date: _____

I understand that Chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulses to the involved tissue, thus allowing the body it's best chance of healing itself. I give the doctors and assistants at Complete Health Chiropractic and Massage full permission to render care to myself and/or my family.

Cancellation Policy

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.

We understand some circumstances are beyond your control, so please discuss with us when cancelling.

No shows will be charged the full treatment amount.

Patient Signature