Infant's Intake - Ages 0-4 years

Parents 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/ASEBPBlue Cross/Medavie Blue Cross? □ YES □ NO
ID# _____ Group# _____

How did you hear about Complete Health? _____

Has your child ever seen a Chiropractor? □ YES □ NO
Who? _____ Date of last adjustment? _____
His/Her Pediatrician / Family Medical Doctor: _____
Date of last visit to Medical Doctor: _____ Purpose:_____
Vaccination history: _____
Childhood Diseases: □ Chickenpox □ Rubella □ Mumps □ Measles □ Whooping Cough
Other: _____
Reactions to vaccinations: _____
What operations has he/she had? When? _____
_____
Has he/she ever been seen in Emergency? □ YES □ NO Why: _____
Has he/she ever been hospitalized? □ YES □ NO Why: _____
Has he/she ever had any bad accidents or falls? □ Yes □ No If so, when? _____
Broken/Fractured bones? □ Yes □ No Which ones? _____

Length of Pregnancy: □ Full term □ Early □ Late
Problems during pregnancy: _____
Location of birth: □ Home □ Hospital: _____ □ Other: _____
Type of birth/delivery: □ Normal □ Vaginal □ Breech □ Cesarean
Invasive procedures: □ Epidural □ Forceps □ Vacuum
Length of labour: _____
Name of obstetrician/midwife: _____
Birth Weight: _____ lbs / kg Birth Length: _____ cm / mm
Presence at birth: □ Jaundice (yellow skin color) □ Cyanosis (blue color) □ N/A
APGAR scores: _____
Congenital anomalies/defects: _____

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: _____
_____
_____

Check any of the following conditions that are a problem CURRENTLY
Circle any that were a problem in the PAST.

- ❑ Sore Muscles
- ❑ Sore Joints
- ❑ Growing Pains
- ❑ Muscle Cramps
- ❑ Muscle Jerking
- ❑ Back Problems
- ❑ Neck Problems
- ❑ Painful Tailbone
- ❑ Pain Between Shoulders
- ❑ Spinal Curvature
- ❑ Arthritis
- ❑ Difficulty Chewing/Clicking Jaw
- ❑ General Stiffness
- ❑ Walking Problems
- ❑ Feet Turn In/Out
- ❑ Coordination Problems
- ❑ Headaches
- ❑ Hearing Problems
- ❑ Hyperactivity
- ❑ Vision Problems
- ❑ Fatigue
- ❑ Allergies
- ❑ Difficulty Sleeping
- ❑ Dizziness
- ❑ Fainting
- ❑ Earaches/Infections
- ❑ Nose Bleeds
- ❑ Sore Throat
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Enlarged Glands
- ❑ Frequent Colds/Flu
- ❑ Poor/Excessive Appetite
- ❑ Junk Food
- ❑ Nervousness
- ❑ Depression/Confusion
- ❑ Dental Problems
- ❑ Stomach Aches
- ❑ Lack Of Full Head/Neck Movement
- ❑ Fussing When Placed In Specific Positions
- ❑ Colic
- ❑ Extreme Fussiness
- ❑ Screaming/Crying
- ❑ Night Terrors
- ❑ Tilting Head To One Side
- ❑ Preferred Side Nursing
- ❑ Difficulty Nursing
- ❑ Slow Weight Gain
- ❑ Hernias
- ❑ Skin Eruptions/Eczema
- ❑ Seizures
- ❑ Loss Of Weight
- ❑ Rheumatic Fever
- ❑ Bedwetting
- ❑ Constipation/Diarrhea
- ❑ Anemia
- ❑ Thyroid
- ❑ Vomiting

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