Confidential Health Record

File # _____

Today's Date: MM / DD / YEAR

Whom may we thank for referring you to our office? NAME _____

● Google ● Walk-in ● Word of mouth ● Other _____

Is this a motor vehicle accident claim? ● Yes ● No **Is this a workers compensation board claim?** ● Yes ● No

Personal Information

Name FIRST _____ LAST _____ **Sex** ● Male ● Female

Address _____ CITY _____ PROV _____ POSTAL CODE _____

Email Address _____

Phone # HOME _____ CELL _____

Birth Date YYYY/MM/DD _____/_____/_____ **Age** _____ **Alberta Health Care #** _____

Parent/guardian name FIRST _____ LAST _____

Parent/guardian email _____

Parent/guardian phone # HOME _____ CELL _____ WORK _____

Hobbies/Recreation/Likes _____

Emergency Contact

Name FIRST _____ LAST _____ **Relationship** ● Parent ● Relative ● Friend

Phone # HOME _____ CELL _____ WORK _____

Current Health Providers

Pediatrician NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Dentist NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Other NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Present Health Challenge

What brings your child to the office today? PLEASE CHECK **ALL** THAT APPLY. WE WILL BE ASKING YOU MORE DETAILS ON THE FOLLOWING DURING THE CONSULTATION.

- The child has no symptoms or complaints. They are here for a chiropractic wellness checkup as part of a healthy lifestyle
- If your child is already experiencing a symptom, please describe it: _____

_____

_____

What caused this conditions to occur? _____

What are your expectations in receiving care with us? _____

Mother's Pregnancy History

Did you experience any of the following complications during your pregnancy? PLEASE CHECK **ALL** THAT APPLY

- Back pain
- Gestational diabetes
- Pre/eclampsia
- Strep B
- Nausea
- Vomiting
- Pre-term
- Fatigue
- Swelling
- Other _____
- Traumas during pregnancy SLIPS, FALLS, ETC _____

Birth History

How long was the pregnancy? _____ WEEKS **Where did the birth take place?** Hospital Birth center Home Midwife

What type of birth was it? Vaginal Breech Cesarean Induced Epidural Forceps Vacuum

Other _____

Did any of the following complications occur during labor and delivery? PLEASE CHECK **ALL** THAT APPLY

- Failure to thrive
- Extended hospitalization
- Respiratory distress
- Congenital anomalies
- Jaundice
- Meconium
- Bruising
- Stuck in birth canal
- Odd-shaped head
- Fast birth
- Excessive long birth
- Cord around neck
- Other _____

Growth & Development

How was the child fed? Breast fed HOW LONG? _____ Bottle Formula **Hours of Sleep** HOURS/NIGHT _____

At what age was your child able to:

Respond to sounds _____ Follow an object _____ Hold head up _____

Sit up alone _____ Crawl _____ Stand _____ Walk _____ Vocalize _____

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Have you vaccinated your chid? ○ Yes ○ No ○ On Schedule ○ Delayed schedule

Is there a family history of any of the following? CHECK ALL THAT APPLY ○ Autoimmune disease ○ Cancer ○ Depression ○ Diabetes ○ Heart disease ○ Multiple sclerosis ○ Osteoarthritis

PLEASE CHECK ALL THAT APPLY. **CIRCLE AREAS THAT ARE OF SERIOUS CONCERN OR MORE PROMINENT.**

Childhood Illnesses	YES	NO
Chicken pox	○	○
Croup	○	○
Diabetes	○	○
Juvenile Arthritis	○	○
Measles	○	○
Mumps	○	○
Rubella	○	○
Scarlet fever	○	○
Thrush	○	○
Tuberculosis	○	○
Whooping cough	○	○
Other	_____	

General	YES	NO
ADHD	○	○
Anemia	○	○
Asthma	○	○
Bed-wetting	○	○
Behaviour problems	○	○
Chronic colds	○	○
Chronic Ear infections	○	○
Colic	○	○
Constipation	○	○
Delayed speech	○	○
Digestive trouble	○	○
Dizziness	○	○
Fainting	○	○
Headaches	○	○

General Continued	YES	NO
Heart trouble	○	○
Hyperactivity	○	○
Hypertension	○	○
Neuritis	○	○
Orthopedic problems	○	○
Poor appetite	○	○
Recurring fevers	○	○
Ruptures/hernias	○	○
Scoliosis	○	○
Seizures	○	○
Sinus trouble	○	○
Temper tantrums	○	○
Walking problems	○	○
Other	_____	

Medications

PLEASE LIST **PRESCRIPTION** AND **OVER-THE-COUNTER** MEDICATIONS YOUR CHILD IS CURRENTLY TAKING

MEDICATION _____ REASON _____ DOSAGE _____ DURATION _____

MEDICATION _____ REASON _____ DOSAGE _____ DURATION _____

MEDICATION _____ REASON _____ DOSAGE _____ DURATION _____

Supplements

PLEASE LIST **NUTRITIONAL SUPPLEMENTS** YOUR CHILD IS CURRENTLY TAKING

SUPPLEMENT _____ REASON _____ DOSAGE _____ DURATION _____

SUPPLEMENT _____ REASON _____ DOSAGE _____ DURATION _____

SUPPLEMENT _____ REASON _____ DOSAGE _____ DURATION _____

Health History

Previous chiropractic care? ○ No ○ Yes

DOCTOR'S NAME _____ LAST VISIT _____ TYPE _____ **Did it help?** ○ No ○ Yes

Have you consulted with other doctors for your condition(s)? ○ No ○ Yes

DOCTOR'S NAME _____ PROFESSION _____ TREATMENT _____ **Did it help?** ○ No ○ Yes

Injuries PLEASE LIST ALL INJURIES SUCH AS A **FRACTURES**, **FALLS**, **BROKEN BONES**, **HEAD INJURIES**, **LACERATIONS** ETC, AND OUTCOME

DATE _____ INJURY _____ OUTCOME _____

DATE _____ INJURY _____ OUTCOME _____

DATE _____ INJURY _____ OUTCOME _____

Motor Vehicle Accidents LIST DATES, TYPE (**REAR END**, **FRONT**, **T-BONE,** OR **OTHER),** IMPACT (**HIGH**, **MEDIUM**, OR **LOW**), AND BRIEF DESCRIPTION OF SYMPTOMS/TREATMENT

DATE _____ TYPE _____ IIMPACT _____ SEATBELT? ____ SYMPTOMS/TREATMENT _____

DATE _____ TYPE _____ IIMPACT _____ SEATBELT? ____ SYMPTOMS/TREATMENT _____

Surgeries PLEASE LIST DATES, PROCEDURE (**ESPECIALLY THOSE THAT REQUIRED GENERAL ANESTHESIA**), AND OUTCOME

DATE _____ PROCEDURE _____ OUTCOME _____

DATE _____ PROCEDURE _____ OUTCOME _____

Allergies PLEASE LIST ALL **ALLERGIES**, **REACTIONS**, AND **TREATMENT**

ALLERGY _____ REACTION _____ TREATMENT _____

ALLERGY _____ REACTION _____ TREATMENT _____

Acknowledgement

An evaluation will be performed which may include a spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, posture analysis and radiological examination.

By signing below, I acknowledge that the information I have provided is accurate and true.

Name _____ **Signature** _____ **Date** _____