Arora Family Chiropractic

Today's Date: _____

CHILD INFORMATION

First Name: _____ Last Name: _____ (On MB Health Card)

Name he/she prefers to go by: _____ Male ____ Female ____ DOB: _____

Mother's Full Name: _____ Father's Full Name: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parents email address (one) : _____

MB Health Number (6 digits): _____ PHIN (9 digits): _____

Who can we thank for referring you to our office? _____

Has your child received chiropractic care before? Y N How long ago? _____

Is there anything else you would like to add?

_____

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The human body is designed to express health and function normally. However, events may occur in life, which can **interfere** with this natural ability. This interference is most commonly caused by **vertebral subluxations**, resulting from **physical, chemical, or emotional stress**.

Chiropractic aims to locate and correct/reduce the vertebral subluxation and nerve interferences to optimize health.

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Reason for Today's Visit

What is the primary reason and/or health concern for your visit today?

_____

When and how did this concern begin? _____

What makes it worse? _____ What makes it better? _____

How is this concern mainly **AFFECTING** your child's **QUALITY OF LIFE**?

_____

Has your child been treated for this condition before and by whom?

_____

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Please check the boxes that most closely describes your current goals for your child's health/well-being:

- ☐ I am mainly concerned about relief of a particular symptom
- ☐ I am mainly concerned about relief of a symptom and preventing its return
- ☐ I want optimum health and well-being on every level available to my child

General Health

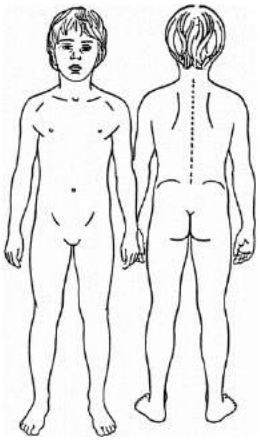
Does your child suffer from: (Please check all that may apply)

- □ Headaches/Migraines □ Ear Infection □ Diarrhea □ Fever
- □ Buzzing in Ear □ Constipation □ Depression □ Loss of balance
- □ Stomach upset □ Sleep problems □ Fainting □ Freq Colds/Flu
- □ Fatigue □ Shortness of breath □ Sinus Problems □ High Anxiety
- □ Asthma □ Dizziness □ Diabetes □ Irritability
- □ Hands/Feet cold □ Pins/Needles/Numbness: Arms or Fingers, Legs or Toes
- □ ADHD □ Bed Wetting □ Growing pains

Does your child feel pain? (Please check all that may apply)

- □ Neck □ Lower Back
- □ Shoulder □ Hip
- □ Elbow □ Chest
- □ Wrist □ Knee
- □ Hand □ Ankle
- □ Mid Back □ Foot

Please mark any area of pain on the figures below



Does your child take any medications? Y N

Which one(s)? _____ For how long? _____

Has your child:

Had surgery? Y N When? _____

Please explain: _____

Been involved in a car accident or any other major fall or trauma? Y N

When? _____ Please explain: _____

Would you say your child eats a balanced diet including: Y N

-plenty of: vegetables fruits proteins healthy fats water

-low in: sugar white products (flour, rice…) processed & fried foods

What kind of exercises/sports is your child involved in? _____

How many times a week? _____ On average, how many hours of sleep every night? _____

What vitamins/supplements is he/she taking? _____

How many hours each day does your child spend watching tv or using electronic devices? _____

Family History of: (Please check all that may apply)

Father's Side: □ Heart Disease □ Cancer □ Arthritis □ Diabetes
Mother's Side: □ Heart Disease □ Cancer □ Arthritis □ Diabetes

Other: _____