LifeWorks FAMILY CHIROPRACTIC

#204, 1740 Gordon Drive ♦ Kelowna, BC ♦ V1Y 3H2 ♦ 250-868-4880

www.lifeworkschiropractic.ca wecare@lifeworkschiropractic.ca

Patient Introduction – Child (to age 12)

Personal History:

Your Name: _____
First (Nick-name) Last

Your Mom: _____ Your Dad: _____

Sibling: _____ Sibling: _____

Sibling: _____ Sibling: _____

Your Mailing Address (including postal code please):

_____

_____

_____

Telephone: Home:_____ Mom's cell: _____

Dad' s cell:_____ Email: _____

Birth Date: Day: _____ Month: _____ Year: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:

_____

_____

_____

Present MD: _____ City: _____

Referred to our Centre by:_____

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Initial Child & Adolescent Questionnaire (to age 12)

Patient's Name: _____ Gender: _____

Your Mom: _____ Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____
_____
_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby=s **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy?

For what? _____ What type? _____

Any exposures to ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table	___ Frequent crying spells
___ Tumble down stairs	___ Frequent fevers
___ Fall out of crib	___ Frequent bouts of diarrhea
___ Involved in car accident	___ Constipation
___ Fall off playground equipment	___ Sleeping problems
___ Play in AJolly Jumper@	___ Frequent colds
___ Frequent ear infections	___ Colic
___ Tonsilitis	___ Did not gain weight
___ Reaction to vaccination	___ Other_____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree	___ Bed wetting
___ Fall of a bicycle	___ Hyperactivity/Autism
___ Fall of playground equipment	___ Learning difficulties
___ Sports accident	___ Asthma
___ Car accident	___ Allergies
___ Stomach pains	___ Leg/knee pains
___ Scoliosis	___ Other_____

Please explain the above: _____
_____
_____

6. Did your child receive any vaccination(s)? If so, which ones:

_____
_____
_____

Any reactions to any of these? _____
_____

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pains	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ AGrowing Pains@
___ Fatigue	___ Weight gain/loss	___ Other _____

Please explain any of the above: _____
_____

OVER

8. **Which of the problems you have checked off is the worst?** _____

_____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ____

9. **How long has it persisted?** _____

10. **When it is at its worst, how does it make your child feel?** _____

11. **What have you done about it that has NOT worked?** _____

_____

_____

12. **What makes it worse?** _____

13. **What effect does this problem have of your child=s body functions**?

_____

_____

On his/her participation in daily activities? _____

14. **Describe any hospital stays:** _____

_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

16. **List any medications your child is currently taking:** _____

_____

17. **To summarize, what is your purpose for this appointment?** _____

_____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

_____

Signature of parent or guardian: _____

Date: _____

***

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are **current health problems** of a family member by the designation **C** under his or her column. The **designation P** should be used **to indicate a past problem**. Leave blank those spaces that do not apply.

Condition	Self	Father	Mother	Spouse	Children		
					Age	Age	Age
ADHD							
Allergies							
Arthritis							
Asthma							
Autism							
Back Trouble							
Bed Wetting							
Bursitis							
Cancer							
Chest Pain							
Colic							
Constipation							
Crohn Disease							
Depression							
Diabetes							
Diarrhea							
Disc Problems							
Down Syndrome							
Ear Infection							
Emotion Issues							
Emphysema							
Epilepsy							
Headaches							
Migraines							
Heartburn							
Heart Trouble							
High Blood Press							
IBS							
Indigestion							
Infertility							
Insomnia							
Kidney Trouble							
Neck Pain							
Neuritis							
Nervousness							
Pinched Nerve							
Scoliosis							
Sinus Trouble							
Other							

Additional Comments:

_____

_____

_____

_____