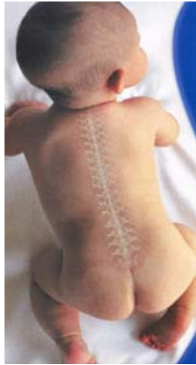

Inside Out Family Chiropractic

Our mission is to help as many people as possible achieve and maintain their optimum health potential, especially children

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Patient Introduction

Personal History:

Patient Name:____
First Middle Last

Your Address: ____
____
____

Telephone: Res:____________ **Bus:**______________ **Email:** ____________________

Health Card: ______________________________ (Please bring health card to front desk)

Birth Date: Day: _________ **Month:** ___________ **Year:** _______________

Marital Status:____________________

Occupation: ____

Employer: ____

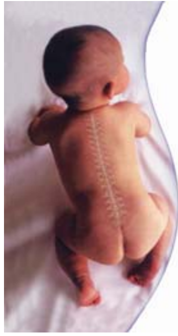
Previous Chiropractor: ____________________ **City:** ______________________

Last visit to this Chiropractor:____________________________________

Reason for leaving: ______________________________________
____

Present MD: ___________________________ **City:** ________________________

Referred to our Centre by:____________________________________



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Child & Adolescent Health Questionnaire

Your Name: ______________________________ Your Mom: _________________________
Your Dad: _________________________

This Part Is Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _________________ If not, how many weeks gestation? __________

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 1 minute? _____/10___ & at 5 minutes? ______/10____

Was there initial respiratory delay? _______ Purple markings on face? ___________

Mis-shaped skull/head? _____________

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? ____

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
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in "Jolly Jumper"
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other____________________

Please explain the above: ____
____
____

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

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

Please explain the above: ____
____
____

6. Tell us about any vaccinations your child has had:

____
____

Any reactions to any of these? ____
Were you told that you had a choice in vaccinating your child? ___**YES**, ___**NO**

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

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

Please explain the above:____
____
____

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)**

Thank You!