Name: _____ Birth Date: _____ (Age _____)
Parents/ Guardians: _____ Sex: _____ Weight:_____ Height:_____
Referred by: _____
_____
Address: _____ Email Address:
City: _____Prov_____ PC_____ _____
Phone: (C) _____ (W) _____

Chiropractic History

Have you previously seen a chiropractor? □ Yes □ No Reason _____
Did they take x-rays? □ Yes □ No
If yes, when was your last visit _____

Main concern for today's visit: _____
_____
Pain or problem started on_____ Why do *you* think it started? _____
Does anything make it worst? □ Yes □ No _____
Does anything make it better? □ Yes □ No _____
Is it worse during certain times of the day? _____ Is it progressively getting worse? □ Yes □ No
Other Doctors seen: _____
Any home remedies? _____ _____

Check any of the following conditions that apply:

□ Ear Infections □ Seizures □ Chronic Colds □ Headaches □ Asthma / Allergies □ ADHD / ADD □ Difficulty in School
□ Digestive Problems □ Recurring Fever □ Growing / Back Pains □ Bed Wetting □ Temper Tantrums □ Scoliosis
□ Difficulty Sleeping □ Other _____

Medical History

Pediatrician/MD: _____ Date of Last Visit: _____ Reason: _____
Vaccination History: _____
Antibiotics or other prescription history: _____
Antibiotics / Vaccines / Medications in past 6 months: _____
Family medical conditions/history: _____

Childhood Diseases:

Chicken Pox: Age ____ N/A Measles: Age____ N/A Mumps: Age____ N/A Rubella: Age ____ N/A
Whooping Cough: Age ___ N/A Rubeola: Age ____ N/A Other_____ Age:____
Significant Illnesses:_____

Prior History:

Complications during pregnancy? □ Yes □ No What Type: _____
Birth Interventions: □ Forceps □ Vacuum Extraction □ Caesarian Section (□ Emergency □ Planned)
Complications during delivery? □ Yes □ No What kind: _____
Genetic disorders or disabilities? □ Yes □ No What type: _____
Food allergies or intolerances: □ Yes □ No List: _____
Developmental concerns/challenges:_____

Accident/Trauma/Injury History:

Involvement in Sports? □ Yes □ No Type:_____
Significant Sports Injuries:_____
Car accidents: □ Yes □ No How many: _____ Approximate dates: _____
Other traumas/accidents/injuries: □ Yes □ No What kind: _____
Surgeries: □ Yes □ No □ What type? _____ When? _____

Any other concerns? _____
_____

Signature _____ Date _____