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INFANT AND CHILDREN FORMS (0-13 years)

Date: ______________________________

Name (first and last): ______________________________ Gender: FEMALE or MALE

Child's Birthdate: ______________________________ Age: __________

Parent(s)/Guardian(s) Name: ______________________________

Address: ______________________________

City/Province: ______________________________ Postal Code: ______________

Phone Number – Home: (____) ______________ Mobile Phone: (____) ______________

Email: ______________________ Check if you **don't** want us to communicate with you by email ☐

Whom may we thank for referring you to Elmira Family Chiropractic? ______________________

Have you or your child ever had chiropractic care before ☐ YES ☐ NO

If yes, please tell us the doctor's name: ______________________________

If yes, dates from: ______________ to ______________

Briefly describe your previous chiropractic experience: ______________________________

____

____

Is your child receiving care from other health professionals? ☐ YES ☐ NO

If yes, please tell us the doctor's name: ______________________________

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WHY this form is important:
As a full spectrum Chiropractic office, we focus on your child's potential for health. Our goals are to address the issues that brought you to our office and to offer your family the opportunity of improved health and wellness services in the future. Answering the following questions to the best of your ability will give us a profile of the specific stresses your child has faced, allowing us to better assess the challenges to their body. Reason(s) for consulting this office:

- ☐ 1. My child has no specific problem, I wish to use chiropractic to enhance their wellness, help them perform better, and allow them to live life at a higher level.

- ☐ 2. My child has a symptom(s) of a physical problem and I want to see if chiropractic will enable their body to work better.

If you checked box 2, fill out CURRENT HEALTH section below. If you checked box 1, skip to Physical Stress.

What present complaint or persistent health challenge brings your child to our office? ____________________

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Has your child had this type of problem before? ☐ YES ☐ NO

If yes, how so? ____

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Have they seen anyone else for this problem? If so, how was it managed? ____________________________

____

How is this affecting your life and theirs? ____

____

Physical Stress or Challenges

Please describe your child's birth process: (at home or hospital, position at birth, vaginal/c-section, use of forceps, vacuum, epidural, induction, episiotomy, complications etc). ______________________________________

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APGAR score at birth : _____________________ APGAR score after 5 minutes: ________________________________

Child's birth weight ________________ Child's birth height _________________

Current Weight: ____________________ Current height ______________________

Please describe any childhood illnesses, hospitalizations, surgeries, serious falls, car accidents:

____

____

Chemical Stress or Challenges

Is your child currently taking any medication (over the counter and/or prescription)?

____

Allergies? ____

Previous medications: ____

Is/was your child predominantly breastfed or formula fed? ________________________________

Does your child consume sugar daily? ____

Is your child exposed to cigarette toxins daily? ____

Has your child received any antibiotics? ☐ YES ☐ NO If yes, how many times and list reasons:

____

Please list any foods/juice intolerance: ____

In your opinion, does your child seem normal for their age? ☐ YES ☐ NO

If no, please explain ____

Emotional Stress or Challenges

List any emotional/mental stressors presently in your child's life and any previous major stressors. (i.e. parents divorcing, bullying, bet wetting etc.) ____

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Goals

What would you like your child to gain from chiropractic care? ____________________________________

____

Are there other health concerns or anything else you'd like us to know about your child? ______________

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