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ELMIRA FAMILY CHIROPRACTIC
est. 1964

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: _____

_____

_____

**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 Health Survey.*

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

_____

_____

Has your child had this type of problem before? ☐ YES ☐ NO Date of Onset: _____

If yes, how so? _____

_____

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

_____

How is this affecting your life and theirs? _____

_____

**Health Survey:** *Check off any of the following symptoms your child has ever had.*

| | | |
|---|---|---|
| ☐ Hyperactivity | ☐ Insomnia/sleep problems | ☐ Headaches |
| ☐ Fatigue/poor sleep | ☐ Irritability/Anxiety | ☐ Bed-wetting |
| ☐ Misbehaviour | ☐ Digestive trouble | ☐ Poor Balance |
| ☐ Asthma/Respiratory issues | ☐ Constipation | ☐ Nervousness |
| ☐ Colic | ☐ Gas/Bloating | ☐ Dizziness |
| ☐ Poor focus/concentration | ☐ Diarrhea | ☐ Repetitive motion |
| ☐ Muscle Stiffness | ☐ Weakness | ☐ Aggression |
| ☐ Hyper/hyposensitivity | ☐ Ear infections | ☐ Colds/flus |
| ☐ Poor motor control | ☐ Poor posture | ☐ Toe walking |

☐ Other _____

Which of the above do you notice the most and how long has it been going on? _____

**Physical Stress or Challenges**

History of Birth Born at: ☐ Home ☐ Hospital ☐ Birthing Centre Duration of gestation: _____ wks

Was birth assisted? ☐ Yes ☐ No If yes, How? ☐ Forceps ☐ Vacuum ☐ C-section ☐ Induced

Were medications given to the mother or baby at birth? ☐ Yes ☐ No If yes, what? _____

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:

_____

_____

Average number of hours of TV/Computer per week? _____ hrs Weight of school backpack? _____lbs

Approx. hours spent playing per week? _____ hrs Does your child play sports? ☐ Yes ☐ No

**Chemical Stress or Challenges**

During pregnancy, did the mother:

| | | | | | |
|---|---|---|---|---|---|
| Smoke | ☐ Yes | ☐ No | Become ill? | ☐ Yes | ☐ No |
| Drink alcohol or take drugs | ☐ Yes | ☐ No | Receive ultrasounds | ☐ Yes | ☐ No |

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

_____

Allergies or sensitivities?

_____

Previous medications:

_____

Is/was your child breastfed or formula fed? How long? _____

Any latching difficulties? _____ Both sides equally? _____

Any difficulties with lactation? ☐ Yes ☐ No If yes, explain: _____

Does your child consume sugar daily? ☐ Yes ☐ No

Is your child exposed to cigarette toxins daily? ☐ Yes ☐ No

Has your child received any antibiotics? ☐ Yes ☐ No If yes, how many times and list reasons why:

_____

Did your child receive any vaccinations? ☐ Some ☐ All ☐ None Any reactions? _____

_____

How often is your child sick? _____

Please list any foods/juice intolerance: _____

**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, bedwetting etc.) _____

_____

_____

Does your child have any behavior problems? Is so, have they been diagnosed? _____

_____

**Goals**

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

If no, please explain _____

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? _____

_____