Child Intake Form

Name :_____Birth date: (M/D/Y)____/____/_____

Parent/Guardian Name(S):_____

Address:_____ Age: _____

City:_____ Province:_____ Postal Code:_____

Home Phone: (____)_____ Cell Phone: (_____)_____

Email Address:_____I consent to receive email correspondence ___

Care Card # (MSP):_____ Sex: ____ Weight: _____ Height:_____

Who referred you to the office?_____

Purpose for Contacting us:_____

Date Problem began: _____

Changes since it began:_____

Others Seen For This Problem:_____

Name of Pediatrician/GP:_____

Check any of the following conditions your child has suffered from?

O Ear Infections O Seizure O Chronic Colds O Headaches

O Asthma/Allergies O Digestive Problems O Colic

O Other _____

Vaccination History:_____

Current or recent medications? _____

Sleep Pattern Normal: Y N **Bowel Movements Normal: Y N**

Trauma/Injuries:

Has your child had any recent falls or trauma?

(What? When?_____

Has your child ever fallen down stairs or fallen from any height?

(Where? When?)_____

Has your child ever been in a motor vehicle collision or near-miss?

(How? When?)_____

Has your child ever had a bone fracture or joint dislocation?

(Where?)_____

Has your child had any other trauma or injuries?

(Describe)_____

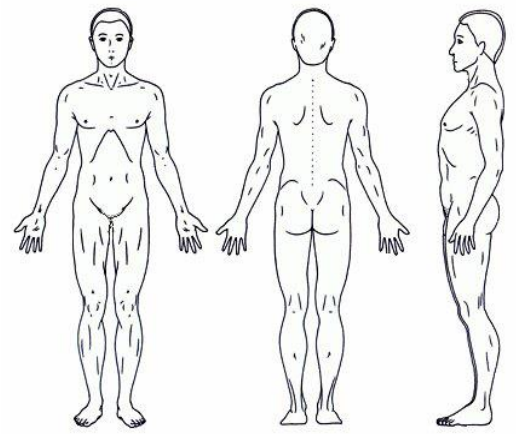
_____

Does your child ever bang his/her head repeatedly against a wall/bed/other object?

YES (Decsribe)_____ NO _____

Any surgeries? _____

Please mark any areas that are concerning for you: (comment as necessary)



Please let us know how we can help you:

___ *I have a specific problem that I want addressed and nothing else*

___ *I am interested in follow-up care to attain and maintain musculoskeletal health*

___ *I have no serious problems today and I would like chiropractic maintenance care*

The information above is true, to my best knowledge, and I authorize my doctor to provide me/child with chiropractic care.

Patient or Parent/Guardian Signature _____

Date _____