georgian family
—CHIROPRACTIC—

801 River Rd. W.
Wasaga Beach, ON. L9Z 2N7
Phone – (705) 422-1221
Fax – (705) 422-1228

CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Date:_____
Name: _____ Date of Birth: _____ Age: _____ Sex: M / F
Address: _____ City: _____ Province: _____ Postal Code: _____
Parent's Home Phone: _____ Parent's Work Phone: _____
Parent's name: _____Parent's Email: _____
Please put an "X" if you **do not** want to subscribe to our monthly newsletter: ____
Who may we thank for referring you? _____

Why this form is important:
In this office, our focus is on helping people to function optimally so that they are stronger, healthier, and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical, and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern
Health concern: _____
When did it begin? _____ How often does it occur? _____
What relieves it? _____
What aggravates it? _____
Other professionals seen for concern: _____
Treatment and results: _____

Birth History
Child's gestational age at birth: _____ weeks Birth weight: _____ Length: _____
Birth experience: Midwife / Medical Labour: Spontaneous / Induced
Any procedures during birth: Forceps / Vacuum extraction / C-section / Episiotomy
Any complications before or after birth? Yes / No
If yes, please explain: _____
Evidence of obvious birth trauma? Bruising / Odd shaped head / Stuck in birth canal

Family Health History
Please note any health issues that are present with family relations:
Brothers: _____
Sisters: _____
Father: _____
Mother: _____
Grandparents: _____

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Physical Stresses

Any significant falls or trauma to the mother during pregnancy? Yes / No / Unsure
For the child, were there any falls from couches, beds, change tables, etc? Yes / No / Unsure
Any hospital visits for concussions, possible fractures or other traumas? Yes / No / Unsure
Have there been any surgeries? Yes / No
If yes, please explain: _____
Is a backpack worn? Yes / No
Does your child participate in sports? Yes / No
Any hobbies or activities which require prolonged, awkward or repetitive postures? (ie: violin, gymnastics etc)
Yes / No / Unsure

Chemical Stresses

During pregnancy, did the mother: use medications? Yes / No If yes, which ones? _____
smoke? Yes / No
drink? Yes / No
Was the child breast-fed? Yes / No If yes, how long? _____
Formula introduced at what age? _____
Began solid foods at what age? _____
Vaccination history: Vaccinations given: _____
Any reactions? Yes / No If yes, please list: _____
Has the child been or is the child currently on any medications? Yes / No
If yes, please list: _____

Mental/Emotional Stresses

Any problems with bonding? Yes / No / Unsure
Any behavioural problems? Yes / No / Unsure
Any night terrors, sleep walking, difficulty sleeping? Yes / No / Unsure
Average number of television hours per week? _____
Do you feel that your child's social and emotional development is appropriate for their age? Yes / No / Unsure

Authorization for care of a minor (under 16 years of age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic staff.

Child's name: _____ Parent's name: _____
Parent's signature: _____ Witness: _____
Date: _____

Thank you for completing this form. If you have any further concerns, please note them in the space below:
_____
_____
_____