



New Patient Profile

Pediatric

(5 - 12 Years of Age)

Patient's Name: _____ Date: _____
Alberta Health Care #: _____ Phone number: _____
Birth Date: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
Mother's Name: _____ Father's Name: _____
Address: _____ City: _____ Prov: _____ P.C.: _____

Motor Vehicle Accident (if applicable)

Are you seeking treatment for a Motor Vehicle Accident? (Circle) YES / NO
Date of Motor Vehicle Accident: _____
Have you seen another practitioner in regards to this accident? (Circle) YES / NO
Type of practitioner: _____ Date of Assessment: _____
Insurance Company: _____ Phone Number: _____
Name of Claim Worker: _____ Claim #: _____

Current Condition

Purpose of this Appointment: _____

Major Complaint: _____

Explain How Complaint Occurred: _____

When did this condition begin?: _____

Condition has persisted for: Days Weeks Months Years

Condition developed from: Auto Accident Work Injury Other Injury _____

Symptoms: Came on suddenly Come & Go

What activities make this condition **better**? _____

What activities make this condition **worse**? _____

Have you ever had this condition before? No Yes, when _____

Other doctors/therapists seen for this condition: _____

Describe other complaints involving:

Neck/Head: _____

Mid-back/Shoulders/Arms: _____

Low-back/Hips/Legs: _____

Past Health History

Medical doctor's name: _____ Location: _____

Last Visit: _____ Purpose: _____

Previous Chiropractic Care: _____

Last Visit: _____ Purpose: _____

Date of last spinal X-rays: _____ Where?: _____

Fractures: _____

Surgeries and Operations: _____

Known Health Conditions: _____

Medication/Supplements/Homeopathics (past & present): _____

Vaccination history: _____

Reactions to vaccinations: _____

Childhood Diseases (please check if applicable)

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Eczema | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Influenza | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anorexia Nervosa |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bulimia |

Past Conditions (please check any this patient may have had)

- | | | |
|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Colds/flu | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Growing pains | <input type="checkbox"/> Always ill |
| <input type="checkbox"/> Neck stiff or sore | <input type="checkbox"/> Walking problems | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Arm pain |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Ear aches/infections | <input type="checkbox"/> Birth trauma (vacuum, forceps, C-section) |

Activities (please check those that this patient participates in)

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Hockey | <input type="checkbox"/> Skiing | <input type="checkbox"/> Swimming | <input type="checkbox"/> Dance |
| <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Skating | <input type="checkbox"/> Running | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Biking | <input type="checkbox"/> Track & Field | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Carries back pack | <input type="checkbox"/> time at desk/computer _____ hours/day _____ hours/evening | | |
| <input type="checkbox"/> Other _____ | | | |

Habits

- | | | | |
|-------------------|--------------------------------|---------------------------------|-------------------------------|
| Diet: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Fast food: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | |
| Quality of sleep: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Falls and Accidents

Please list all minor and serious falls or injuries this patient has experienced. Keep in mind the above activities, motor vehicle accidents, slips, etc...

Family History

	Diabetes	Cancer	Heart	Back
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

I confirm that the information that I have provided in regards to the current condition and past health history are true to the best of my knowledge. I am also confirming that I am the legal guardian of this minor.

Name of Parent/Guardian: _____ Date: _____

Signed: _____ Relationship: _____

Witness: _____ Date: _____