doctor FOR moms | perinatal & pediatric natural health center

New Patient Profile
Infant
(0 – 5 years)

Dear Parent:

Please complete this questionnaire. Your answers will help determine if Chiropractic can help your child. Please answer ALL questions, even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your case.

Child's Name:_____ Parents' names:_____
Health Ins. No:_____ Birth date: _____Birth Place:_____
Age: _____ Weight: _____ Height: _____Gender:_____

Phone: Home _____ Address: _____ Postal Code: _____
Email:_____
* Please note that we are collecting your email address to send your recipets, remind you of appointments, or to reach you for a specific/urgent reason. If you would like to be added to our newsletter mailing list please check here _____

School / Daycare: _____ Family MD/Pediatrician: _____
Referred to this office by _____
Who is responsible for the bill? · Parent · Guardian · Other _____
Insurance other than Alberta Health Care (London Life, Blue Cross, etc.)_____
Emergency Contact: _____ Contact Number: _____

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 #: _____

Condition

Present complaint _____
Previous treatment for this condition _____
When did this condition begin?_____
Are there others in your family with this same condition?/or spinal conditions?_____
What do you believe caused this condition? _____
Presently taking medication/Supplements/Homeopathics? (please mention)
_____

Past Health History

Birth History

Length of Pregnancy: · Full term · Early_____ · Late_____
Problems during pregnancy (Blood pressure, baby position) _____
Location of birth · home · hospital · birthing center
Type of birth/delivery: · normal vaginal · breech · cesarean
Invasive procedures: · epidural · forceps · vacuum
Length of labour: _____ · normal · difficult
Name of obstetrician/midwife: _____
Birth Weight: _____ Birth Length: _____
Presence at birth of · Jaundice (yellow skin color) · cyanosis (blue color)
APGAR scores: _____ _____
Congenital anomalies/defects: _____

Infancy History

Feeding: · Breast · Bottle · Formula – if yes, at what age did you start? _____

Latching well? · yes · no

Breast preference? · no · yes · left · right

# of hours of sleep each night: _____ # of hours of sleep in a row _____

Quality of sleep: · Good · Fair · Poor

General Health History

Falls or injuries: _____

Surgeries/Stitches/X-rays: _____

Treatment for any health condition in past year: · yes · No If yes explain:

_____

_____

Previous chiropractic care and approximate date of last visit: _____

Vaccination history: _____

Reactions to vaccinations: _____

Last pediatrician appointment: _____

Please circle any of the following conditions that are a problem; and underline any that were a problem in the past.

MUSCLE & JOINT

- **sore muscles**
- **sore joints**
- **growing pains**
- **muscle cramps**
- **muscle jerking**
- **back problems**
- **neck problems**
- **painful tailbone**
- **spinal curvature**
- **arthritis**
- **feet turn in/out**
- **headaches**
- **pain between shoulders**
- **difficulty chewing/clicking jaw**
- **general stiffness**
- **walking problems**
- **coordination problems**

GENERAL

- **fatigue**
- **allergies**
- **difficulty sleeping**
- **dizziness**
- **fainting**
- **earaches/infections**
- **nose bleeds**
- **sore throat**
- **asthma**
- **seizures**
- **stomach aches**
- **hyperactivity**
- **chronic cough**
- **enlarged glands**
- **loss of weight**
- **poor/excessive appetite**
- **junk food**
- **nervousness**
- **depression/confusion**
- **hernias**
- **vision problems**
- **rheumatic fever**
- **hearing problems**
- **behavioral problems**
- **dental problems**
- **colic**
- **extreme fussiness**
- **screaming/crying**
- **night terrors**
- **tilting head to one side**
- **preferred side nursing**
- **difficulty nursing**
- **slow weight gain**
- **fussing when placed in specific positions**
- **lack of full head/neck movement**
- **frequent colds/flu**
- **epilepsy**

ORGANS

- **bedwetting**
- **constipation/diarrhea**
- **anemia**
- **thyroid**
- **vomiting**
- **skin eruptions/eczema**

OTHER CONCERNS:

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.

Names of Parent/Guardian: _____

Signed: _____ **Relationship:** _____

Date: _____ **Witness:** _____