ZAHARIA CHIROPRACTIC

Date: _____

PEDIATRIC FORM

Please fill out this form in detail. The information will be used to assist the doctor in best serving your child.
The information is confidential and will only be used for clinical purposes.

Child's Name:_____ Preferred Name:_____

Birth Date:_____ (Age:_____) Sex: ◯ Female ◯ Male

MANITOBA HEALTH NUMBERS REG #:_____ Personal Health ID # (9-digits):_____

Address: _____ City, Prov., Postal Code:_____

Names of Parents/Guardians:_____

Siblings names and ages:_____

Home Phone #:_____ Work #:_____ Cell #:_____

How did you discover our office?_____
Has your child ever been checked by a Doctor of Chiropractic? ◯ Yes ◯ No If yes, date of last visit?_____
How would rate you experience? ◯ positive ◯ negative ◯ neutral Reason:_____

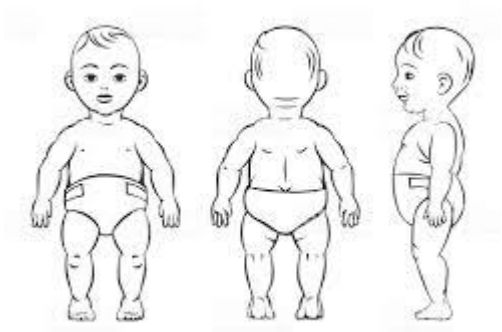
CURRENT AND PAST HEALTH HISTORY

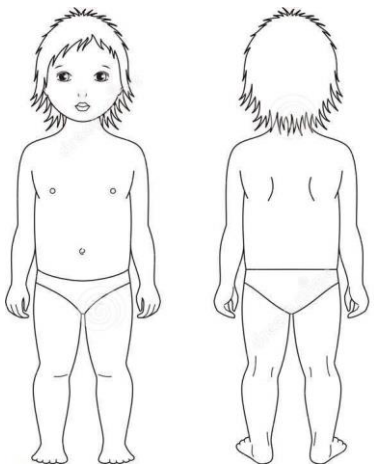
Please use this space to describe the reason for today's visit.

Major Concern: _____ When did it start? _____
Since the problem started, is it: ◯Getting Better ◯About the same ◯Getting Worse
What makes it better? _____
What makes it worse? _____
Any associated symptoms? _____
Other Doctors seen for this problem: ◯Yes ◯No If yes, what was the diagnosis and treatment? _____
_____
_____

Any other concerns/reason for today's visit?_____
_____
_____

If needed, use the diagram of the infant or toddler to indicate areas of concern:





Please indicate if your child has suffered from or been diagnosed with any of the following conditions:

◯ ADD/ADHD	◯ Colic	◯ Growing Pains	◯ Recurring Fevers
◯ Allergies	◯ Congenital Deformity	◯ Headaches	◯ Scoliosis
◯ Asthma	◯ Ear Infections	◯ Irregular Sleeping Patterns	◯ Seizures
◯ Autism Spectrum	◯ Emotional Disorders	◯ Learning Disability	◯ Tantrums
◯ Bed Wetting	◯ Frequent colds	◯ Night Terrors	◯ Tongue/Lip Ties
◯ Cerebral Palsy	◯ Genetic Disorders	◯ Poor Digestion	◯ Weight Problems

◯ Other _____

Duration of Gestation: _____ weeks Birth Weight: _____ Birth Length:_____

•Did mother have ultrasounds during the pregnancy?..... ◯ Yes ◯ No If yes, how many and why?_____

•Did mother take medication during pregnancy or during labour?.....◯ Yes ◯ No _____

•Where was the place of birth?..... ◯ Home ◯ Birthing Centre ◯ Hospital ◯ Other: _____

•Provider?..... ◯ Midwife ◯ Ob-Gyn ◯ Other: _____

•Type of Birth?..... ◯ Vaginal ◯ C-Section (emergency or planned) ◯ Breech

• Was anaesthesia used?..... ◯ Yes ◯ No If yes, type? ◯ Epidural ◯ IV ◯ Other:_____

• Was labour induced?..... ◯ Yes ◯ No If yes, why? _____

• Birth Trauma?..... ◯ Doctor assisted (twisting, pulling) ◯ Forceps ◯ Vacuum extraction

Any other important information regarding the pregnancy and birth of the child:

_____

_____

•Is/Was your child breast-fed?..... ◯ Yes ◯ No If yes, how long? _____

•Does your child have any food intolerances?..... ◯ Yes ◯ No If yes, what? _____

•How would you rate your child's diet?..... ◯ Good ◯ Average ◯ Poor

List your child's 3 favourite foods: _____ _____ _____

If yes for any of the following, please describe/list:

•Has your child had any major falls? ..... ◯ Yes ◯ No _____

•Has your child been in any car accidents ..... ◯ Yes ◯ No _____

•Does your child play any sports ?..... ◯ Yes ◯ No _____

•Is your child currently taking any medications?..... ◯ Yes ◯ No _____

•Has your child ever had any prolonged use of medications? ◯ Yes ◯ No _____

•Has your child been vaccinated?..... ◯ Yes ◯ No _____

•Has your child had any surgery or been hospitalized?.....◯ Yes ◯ No _____

•Has your child been diagnosed with any physical or mental disabilities? ...◯ Yes ◯ No _____

•Has your child suffered emotional trauma? .....◯ Yes ◯ No _____

List any family history of diseases/conditions (ie cancer, heart disease, depression) and who they are in relation to the child:

_____

_____

Please give us any other health information you feel would be helpful:

_____

_____

_____

THE STATEMENTS MADE ON THESE FORMS ARE ACCURATE TO THE BEST OF MY RECOLLECTION AND I AGREE TO ALLOW THIS OFFICE TO EXAMINE MY CHILD FOR EVALUATION.

Parent/Guardian Signature:_____ Date:_____

ZAHARIA CHIROPRACTIC