BRENTWOOD CHIROPRACTIC CLINIC

Move Better. Feel Better. Live Better.

PEDIATRIC INTAKE FORM (3 + YEARS) **Date:** _____

Name: _____ _____ Date of Birth: _____ Age: _____ Male / Female

Address: _____ City: _____ Province: _____ Postal Code: _____

Alberta Healthcare #: _____

Parents/Guardians: _____ Phone #: _____

How did you hear about our clinic? _____

Have you ever had chiropractic care before? **Yes** **No** Name of last chiropractor: _____

REASON FOR VISIT

Please circle all that apply:

Wellness/Preventative Care **Poor Posture** **Improved Athletic Performance**

Area(s) of complaint/Concern:_____

When did the problem start? _____

Was this related to a fall or accident? **Yes** **No** Please describe: _____

_____

Describe the pain/problem: _____

_____

If any of the following conditions have been experienced in the past, please mark with a **"P"** for past. If any of the following conditions are currently being experienced, please mark with a **"C"** for current. Leave blank any that do not apply.

__Headaches	__Diarrhea	__Neck pain	__Nausea
__Ear infections	__Constipation	__Mid back pain	__Loss of appetite
__Allergies (seasonal)	__Bed-wetting	__Low back pain	__Frequent urination
__Allergies (food/other)	__Colic	__Knee pain	__Frequent thirst
__Sinusitis	__Asthma	__Ankle sprains	__Pain in leg
__Hyperactivity	__Indigestion	__Fatigue	__Mood disorder
__Difficulty sleeping	__Learning difficulties/delays	__Eczema	__Skin Issues

Sleep: **Good** **Fair** **Poor**

Current medications (including vitamins/supplements):_____

Dr. Roger G. Jones & Dr. Craig Breckenridge
#108, 937 Fir St. Sherwood Park, AB T8A 4N6 - 780-467-0892 - Fax: 780-467-9835
www.brentwoodchiropractic.ca Follow us on Facebook @ Brentwood-Chiropractic-Clinic

Patient Name: _____ Date: _____

HEALTH HISTORY

Birth:

Was the birth assisted? **Yes** **No**

If yes, how? **Forceps** **Vacuum Extraction** **C-Section** **Induced Labour**

Duration of Birth: _____ Was the delivery normal? **Yes** **No**

Did your child receive vaccinations? **Yes** **No** If yes, which ones? _____

Did your child react to them? **Yes** **No**

Development:

Does or did your child have any of the following (Please check all that apply):

__Difficulty with crawling (on all fours, scoot, army crawl)
__Difficulty learning to ride a bike
__Difficulty learning to read
__Difficulty using utensils
__Difficulty tying shoes
__Poor hand-eye coordination
__Skipping milestone: Roll, Sit, Crawl, Stand, or Walk
__Appears clumsy
__Difficulty writing
__Difficulty buttoning clothing
__Difficult or awkward to walk/run
__Difficulty sitting or paying attention

At what age did your child start to walk unassisted: _____

Neurological/Other:

Has your child ever been diagnosed by a medical professional with any of the following:

__Hearing loss or impairment
__Neurological disorders
__Obsessive Compulsive Disorder
__ADD/ADHD
__Dyslexia
__Visual Impairment
__Anxiety/Depression
__Autism/Autism Spectrum Disorder
__Tourette's Syndrome
__Other:_____

If yes, by whom? _____

General Activities:

__heavy backpack (more than 15% of body weight)
__plays video games __hours/day
__soft drinks __drinks/day
__sleeps on stomach
__exercise __hours/day
__computer/iPad use __ hours/day

Food:

Approximate consumption per day: Water _____ Milk_____ Soda/Other_____

How would you rate your child's diet: **Good** **Fair** **Poor**

Other Concerns or Questions: _____

_____

_____

Dr. Roger G. Jones & Dr. Craig Breckenridge
#108, 937 Fir St. Sherwood Park, AB T8A 4N6 - 780-467-0892 - Fax: 780-467-9835
www.brentwoodchiropractic.ca Follow us on Facebook @ Brentwood-Chiropractic-Clinic