Date:

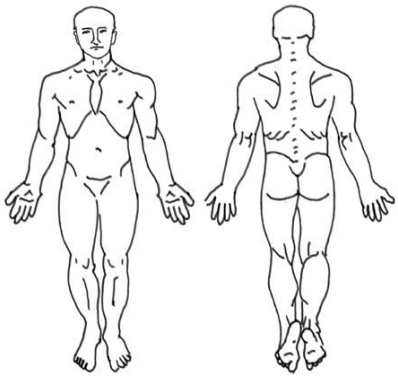
CHILD INTAKE (12 AND UNDER)

Child's Name:	Mother's Name:	Father's Name:	
Birth Date (DD/MM/YY):	Age:	Sex:	
Birth Weight:	Current Weight:	No. of Siblings:	
Address:	City/Town:	Province:	Postal Code:
Home Phone:	Mother's Cell:	Father's Cell:	
Alberta Healthcare Number:			
Pediatrician/Family MD:	Located at:		
Date of last visit to MD:	Purpose of visit:		
Immunization History:			
Purpose of this appointment:			
Has your child ever been treated on an emergency basis? ❒ yes ❒ no			
Describe:			

BIRTH PROCESS:

Yes	No	Not Sure	
❒	❒	❒	Were you a breach baby?
❒	❒	❒	Were forceps used?
❒	❒	❒	Was your mother injured?
❒	❒	❒	Were you Cesarean?
❒	❒	❒	Was the delivery long or difficult?

Please mark areas of pain, numbness or injury.



CHILDHOOD/ADOLESCENCE:

Yes	No	Not Sure	
❒	❒	❒	Did you have colic?
❒	❒	❒	Frequent colds, coughs, or ear infections?
❒	❒	❒	Any neck or back pains?
❒	❒	❒	Bedwetting difficulties?
❒	❒	❒	Were you taught how to care for your spine?

Please list any major illnesses, surgeries or broken bones:

_____

PEDIATRIC CASE HISTORY:

HAS THIS CHILD EVER SUFFERED FROM:

Neonate/Infant Problems:	**Orthopedic Problems:**	**Neurological:**	**General:**
❒Head Shape Concerns	❒Neck Problems	❒Headaches	❒Allergies
❒Head Position/Favouring	❒Backaches	❒Dizziness	❒Asthma
❒Breastfeeding Difficulties	❒Low Back Problems	❒Fainting	❒Recurrent ear infection
❒Hip Concerns	❒Arm Problems	❒Behavioral Problems	❒Stomach Aches
❒Leg/Feet Concerns	❒Leg Problems	❒ADD/ADHD	❒Constipation
❒Digestion Concerns	❒Feet/Ankle Problems	❒Paralysis	❒Diarrhea
❒Shoulder/Arm Concerns	❒Growing Pains	❒Seizures	❒Heart Problems
❒Erb's Palsy	❒Neck Problems	❒Headaches	❒Poor/Excessive Appetite
			❒Diabetes
			❒Frequent Nausea
			❒Vomiting
			❒Excessive Thirst

CHILDHOOD DISEASES

❒Chicken Pox	❒Mumps	❒Measles	
❒Whooping Cough	❒Rubella	❒Rubeola	❒Other:_____

FAMILY HISTORY

❒Cancer ❒Diabetes ❒Heart Disease ❒Depression ❒Allergies

SLEEP HABITS

❒Good Sleeper ❒Poor Sleeper ❒Side ❒Back ❒Stomach

Medications/Vitamins:_____

Sports/Hobbies:_____

Reason for this visit:_____

FINANCIAL POLICY

Fees for professional services are payable when the service is rendered. Parents/legal guardians are responsible for fees for service.

I understand and agree to the Shiloh Chiropractic Financial Policy.

_____

Patient / Parent / Guardian Signature