Pediatric Intake

Synergy Chiropractic & Health Rehabilitation Centr
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Markham, ON L3R 0A9
905 479 3030

Introduction

Contact

First Name_____ Last Name_____

Address _____

City_____ Prov_____ Postal_____

Gender Male Female Date of Birth_____

Height _____ Weight _____

Parent/Guardian

First Name_____ Last Name_____

Home Phone_____ Cell Phone_____ Email_____

How did you hear about us? Location Patient Physician Advertisement Attorney

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History

Complications during pregnancy? Yes No

Ultrasounds during pregnancy? Yes No

Medications during pregnancy? Yes No

Cigarette/alcohol use during pregnancy? Yes No

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Location of Birth: Hospital Home Other

Birth intervention performed: Forceps Vacuum Ex. C-Section None

Delivery Medication? _____

Delivery Complications? Yes No

Birth Weight _____ Birth Length_____ APGAR Scores_____

Breast Fed? Yes No

Formula Yes No

Name of Pediatrician _____ Date of Last Visit _____

Reason for Visit_____ Treatment_____

At what age, in months, was the following introduced?

Solids:_____ Cows's Milk:_____

At what age, in months, was your child able to?

Respond to Sound: _____ Respond to Visual Stimuli: _____ Hold Head Up: _____

Stand Alone: _____ Crawl:_____ Walk Alone:_____

Sit:_____

Personal Illness History ADHD Falling Allergies Asthma Auto Accident Bed Wetting Chronic Colds Colic Constipation Diarrhea Digestive issues Ear Infections Headaches Recurring Fevers Scoliosis Seizures Temper Tantrums Traumat. Birth Vaccine Reaction Other

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Vaccination history_____

Family History_____

Please list any vitamins, herbs, or minerals the child takes:_____

Childhood Diseases

Chicken Pox Yes No

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Rubeola Yes No

Whooping Cough Yes No

Rubella Yes No

Mumps Yes No

Other Yes No

Childhood Injuries

Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Surgery Yes No

Number of doses of antibiotics your child has taken:

Last 6 months: _____ Since birth: _____

Number of doses of other prescription medications your child has taken:

Last 6 months: _____ Since birth: _____

Child's daily habits (skip any questions that do not apply):

Hours of sleep per night (1-24) _____

Child's exercise Heavy Daily Moderate None

Average amount of time spent watching TV, playing video games, or using a computer per day: None 1-3 4-6

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7-12 Over 12

How often does this child consume:

Caffeine Drinks: Never Occasionally Daily

Sugar/sweets: Never Occasionally Daily

Dairy Products: Never Occasionally Daily

Wheat Products: Never Occasionally Daily

Fruits/Vegetables: Never Occasionally Daily

Water as a beverage: Never Occasionally Daily

Condition

Present problem:_____ First occurrence of condition:_____

Did something specific cause this condition? (please describe)_____

Since the problem started, is it: Improving Same Worse

Does anything make it better? Yes No

_____

Does anything make it worse? Yes No

_____

Other health professionals seen for this problem (please list name and dates if applicable)

Chiropractor _____

Medical Doctor_____

Other_____

Finalize

Please Read the following carefully before signing.

**After agreeing, please sign and click Submit below.

Relationship to patient _____

Parent/Guardian Signature: