# Kids Intake Form

Bruce Street Family Chiropractic
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## Symptoms

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this appointment:_____

Have you tried anything to ease this problem?_____

If you don't get this problem corrected, do you think it will get worse in the next 5 - 10 years? Yes No

On a scale of 1 to 10 (10 being the highest), what is your commitment to getting this problem corrected and improving your child?s health? (Circle)


Birth - 4 Years Fall from change table fall down stairs involved in car accident fall from playground equipment play in a 'Jolly Jumper' frequent ear infections frequent crying spells frequent fevers frequent bouts of diarrhea constipation colic sleeping problems frequent colds

5 - 12 Years fall from tree fall off bicycle fall from playground equipment hyperactivity sports accident involved in car accident injury from siblings stomach pain learning disability allergies/ hay fever asthma

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Vaccinations tetanus polio measles mumps rubella pertussis hepatitis B diphtheria haemophilus Influenzae type b rotavirus pneumococcal disease varicella meningococcal disease influenza human papillomavirus

Reactions to vaccinations? _____

Has your child experienced any of the following? headaches dizziness tinnitus earaches allergies/ hay fever asthma frequent colds fatigue sleeping difficulties mood changes 'growing pains'

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excessive gas/ bloating  stomachaches  walking problems  tingling or numbness

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pain

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spinal curvature  jaw problems  fever  nervousness/ depression  anxiety / fear

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Which of the problems that you?ve checked off are you most concerned about? _____

Is there anything else you feel we should know? _____

By signing here, I verify that the above information is true and accurate regarding my child?s health history.

## Personal Info

PEDIATRIC CONFIDENTIAL PATIENT HEALTH RECORD

Child?s First Name: _____ Child?s Last Name: _____

Parents? or Guardians? Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Extended Health Insurance? yes no

_____ Child?s Date of Birth _____

Sex: M F

Special needs or allergies _____

Height _____ Weight _____

Has your child ever received chiropractic care before? yes no approximate date of your child?s last visit: ___

Doctors name: _____ Child?s current medications if any? _____

MD?s name: _____

Spinal x - rays taken in the last 12 months? yes no

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How did you hear about our office? _____

ABOUT YOUR HEALTH

# Kids Intake Form

The human body is designed to be healthy. Throughout life, events occur which can damage your child?s health expression

Our goal is to uncover the layers of injury or damage (especially to your child?s nervous system), that result in lowered health.

Following the consultation, the doctor may recommend a specific course of examinations in order to determine whether your child has spinal nerve stress causing interference with inborn health potential.

LOSS OF WELLNESS

Your child?s birth process?

Was the delivery: long and/or difficult

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forceps vacuum extraction caesarean breech? midwife - assisted home birth hospital birth

APGAR score: _____

Were you given: drugs epidural induced - gel induced - drip

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Health Habits?

Did you smoke during pregnancy? yes no

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Do you or any family members currently smoke? yes no

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Did you drink alcohol during pregnancy? yes no

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Did you take medication during pregnancy? yes no

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Did you breastfeed? yes no

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Does your child exercise regularly? yes no

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Sleeping Posture: side stomach back restless

#of pillows: _____ How long does your child sleep per night? _____

Total hrs. Sleep Quality (circle):


Poor Excellent

Hospitalization?

Has your child ever been hospitalized? yes no

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Has your child ever been prescribed antibiotics? yes no

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Has your child had any surgeries? yes no

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Rate your child?s stress level on an average day (circle number):


Very Low Very High