

# 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

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

pain

spinal curvature   jaw problems   fever   nervousness/ depression   anxiety / fear

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**

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

# Kids Intake Form

Sleeping Posture:    side    stomach    back    restless

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

Total hrs. Sleep Quality (circle):



Hospitalization?

Has your child ever been hospitalized?    yes    no

Has your child ever been prescribed antibiotics?    yes    no

Has your child had any surgeries?    yes    no

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

