CHIROPRACTIC SPINAL CARE CENTRE

arise
VERNON'S WELLNESS HEADQUARTERS

Infant and Child Patient Information

(Infant to 12yrs old)

Date: _____ Health Care No:_____

Name: _____ Address: _____

Mother's Name: _____ Father's Name: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Parent's Business Phone: _____

Patient Birth Date: _____ Age: _____ Sex: M F

Number of Siblings: _____ Age of Siblings: _____

How did you find out about our centre? _____

HEALTH HISTORY

Major complaints: (Please list in order of severity)

1)_____ 3)_____

2)_____ 4)_____

[ ] No complaint. If your child is in for general evaluation (Skip Section A - go to Section B)

A

How long has the condition been present? _____ How did it occur? _____

Did the problem occur: [ ] immediately [ ] gradually

Did this ever happen before? [ ] Yes [ ] No

The problem: [ ] Comes and go [ ] Constant

The problem seems to be: [ ] getting better [ ] getting worse [ ] staying the same

List any medications being used: _____

What makes it better? _____ What makes it worse? _____

Have you seen another doctor about this problem? [ ] yes [ ] no. If yes, when? _____

Doctor's Name: _____ Treatment: _____

Have you tried home remedies? [ ] yes [ ] no If yes, explain _____

B

Were there any problems during pregnancy or childbirth? _____

Child's quality of sleep: a) good b) fair c) poor d) restless

Has your child had any broken bones? [ ] yes [ ] no Which bones? _____

Has your child experienced any dislocations? [ ] yes [ ] no Where? _____

Has your child been involved in a Motor Vehicle Accident? [ ] yes [ ] no

Are there heredity conditions in your family? [ ] yes [ ] no

Are you following an immunization program? [ ] yes [ ] no Any reaction to shots? [ ] yes [ ] no.

Below is a list of conditions which may seem unrelated to the purpose of your child's appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOUR CHILD HAS OR HAS HAD:

[] Appendicitis
[] Scarlet Fever
[] Diphtheria
[] Typhoid Fever
[] Pneumonia
[] Rheumatic Fever
[] Small Pox
[] Tuberculosis
[] Whooping Cough
[] Anemia
[] Measles
[] Mumps
[] Chicken Pox
[] Diabetes
[] Cancer
[] Heart Problems
[] Influenza
[] Eczema
[] Arthritis
[] Epilepsy
[] Mental Disorder
[] Polio
[] Asthma

CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD:

[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Difficulty Chewing/ Jaw Problems

NERVOUS SYSTEM CODE
[ ] Numbness
[ ] Paralysis
[ ] Dizziness
[ ] Confusion/Depression
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities
[ ] Weakness

GENERAL CODE

[] Allergies
[] Loss of Sleep
[] Fever
[] Headaches
[] Attention Deficit Disorder

[ ] Gas/ Bloating After Meals
[ ] Black/Bloody Stool
[ ] Leg Pain
[ ] Colitis

GENITO -UNINARY CODE
[ ] Bladder Trouble
[ ] Painful/Excessive Urination
[ ] Discoloured Urine

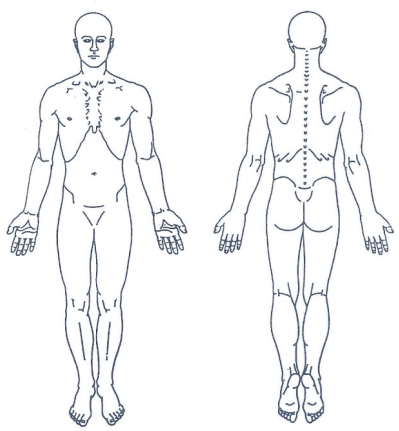
C-V-R
[ ] Chest Pain
[ ] Short Breath
[ ] Lung Problems/Congestion

EENT CODE
[ ] Vision Problems
[ ] Dental Problems
[ ] Sore Throat
[ ] Ear Aches
[ ] Hearing Difficulty
[ ] Stuffed Nose
[ ] Eye Infection
[ ] Watery or Swollen Eyes

GASTRO -INTESTINAL

[ ] Poor/Excessive Appetite
[ ] Excessive Thirst
[ ] Frequent Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Weight Trouble
[ ] Abdominal Cramps or Pain

SHOW US WHERE IT HURTS



Please list any other health problems you feel may be important:

Date_____

_____

_____

Patient Name _____