Pediatric Intake Form

Date: _____ Alberta Health Care # _____

Name: _____ DOB (MM/DD/YY) _____ Male/Female

Address: _____ City _____ Prov _____ Postal Code_____

Mothers Name: _____ Mothers Number: _____

Fathers Name: _____ Fathers Number: _____

Home Phone: _____ Number of siblings: Brothers: _____ Sisters:_____

Birth Weight:_____ Current Weight: _____ Birth Length:_____ Current Length:_____

Reason for Childs visit: _____

Child spends most of the WAKING HOURS with:

a) Mother b) Father c) Grandparents d) Sitter e) Daycare f) Other

Child is exposed to tobacco smoke on a daily basis Yes_____No_____

ABOUT MOM DURING PREGNANCY

Cigarettes: a) Has never smoked b) no longer smokes c) grandparents d)continued smoking regularly(if so, how much?) _____

Alcohol: None_____ Yes_____ if yes, how much? _____

Medication: None_____Yes_____ if yes, what? _____

Other drugs: None_____ Yes_____If yes, what? _____

Mother's and/or Childs problems DURING pregnancy None_____ Yes_____ if yes please comment

_____

_____

BIRTH HISTORY

Was pregnancy full term? Yes___ No __ if no, when was the delivery?
_____
_____

Place of Birth: a) Home b) Hospital c) Birthing Center d) Other: _____

Birthing Assisted by: a)Obstetrician b) G.P c) Midwife d) Other: _____

Manner of Birth: a) Normal Vaginal b) Forceps Assisted c) Cesarean

Labor was: a) Average b) Easy c) Prolonged d) Extremely Rapid Approximate time:_____

Problems encountered during LABOR/DELIVERY? None_____ Yes_____ if yes, please comment
_____
_____

As a Newborn what was the APGAR score? _____

As a Newborn did the child have jaundice? No_____ Yes_____

Infant Feeding

Breast Fed: No_____ Yes_____ if yes, how long? _____

Formula Type: _____

Solids: When did you start?: _____

Additional Supplements: _____

Are there any problems with the feeding schedule? No_____ Yes____ What have you noticed?
_____
_____

GENERAL

History of Colic: No_____ Yes_____if yes, what time is the crying most intense?
_____

Number of hours of sleep per night? _____ Time put down for the night _____

Quality of sleep a)Good b) Fair c)Poor d) Restless e) Fussy

Are bowel movements regular? Yes_____ No_____

Are bowel movements yellowish color and toothpaste consistency? Yes_____ No_____

If no explain_____

Does your child normally feel stiff on being picked up? No_____ Yes_____

Does your child have any history that may be considered unusual? No_____ Yes_____

Comments:

_____

Please place a check mark beside ANY of the FOLLOWING that are a concern:

Recurrent Eye Infection_____ Digestive Problems _____ Congested Breathing _____ Recurrent Ear Infection _____ Sluggishness_____ Mouth Breathing_____ Coordination _____

Recurrent Throat Infection _____ Restlessness_____ Grasping Skills_____ Eye Focus Skills_____
Others_____

Are there any hereditary conditions in your families (Mother or Father) that MAY affect your Childs health? No_____ Yes _____ Comment: _____

State approximate age when the following activity took place:

a) Sat up (unsupported) _____
b) Crawled _____
c) Stood up with support_____ without_____
d) Walked _____

Has the child had a: (please circle appropriate letter and note age and problem)

a) Childhood Disease: _____
b) High Fever: _____
c) Reaction to medications: _____
d) Reaction to foods eaten: _____
e) Reaction to environmental allergens: _____

Name of Pediatrician and/or G.P. _____
Date of LAST visit to G.P _____Pediatrician _____
Purpose: _____

Are you following a infant vaccination program? Yes_____ No_____
Have there been any adverse affects from vaccinations? No_____ Yes_____
If yes, by whom? _____

FINANCIAL POLICY

CHILDREN/STUDENTS

Initial Consultation (Includes Exam and Spinal Screening	$50.00
Regular Chiropractic Adjustment	$30.00
Re- examinations (includes Chiropractic Treatment)	$50.00
Extended Visits: Acupuncture or Laser with Adjustment	$65.00

I clearly understand and agree that all services charged directly to my child is my responsibility. I also understand that if I suspend or terminate my child's care treatment, any fee for professional services to my child will immediately be due and payable.

Parent/ Guardian Signature: _____

Consent to treat a minor:

I am the parent and/or guardian of this child and provide consent for this child's treatment

Parent/ Guardian Signature: _____