



25 Industrial Dr Unit 1B
Elmira, Ontario
N3B 3K3
www.elmiraafc.com
team@elmiraafc.com
INFANT AND CHILDREN FORMS (0-13 years)

Date: _____

Name (first and last): _____ Gender: FEMALE MALE

Child's Birthdate: _____ Age: _____

Parent(s)/Guardian(s) Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Phone Number - Home: (____) _____ Mobile Phone: (____) _____

Email: _____ Check if you **don't** want us to communicate with you by email

Whom may we thank for referring you to Elmira Family Chiropractic? _____

Have you or your child ever had chiropractic care before YES NO

If yes, please tell us the doctor's name: _____

If yes, dates from: _____ to _____

Briefly describe your previous chiropractic experience: _____

Is your child receiving care from other health professionals? YES NO

If yes, please tell us the professional's name: _____

WHY this form is important:

As a full spectrum Chiropractic office, we focus on your child’s potential for health. Our goals are to address the issues that brought you to our office and to offer your family the opportunity of improved health and wellness services in the future. Answering the following questions to the best of your ability will give us a profile of the specific stresses your child has faced, allowing us to better assess the challenges to their body. Reason(s) for consulting this office:

- 1. My child has no specific problem, I wish to use chiropractic to enhance their wellness, help them perform better, and allow them to live life at a higher level.
- 2. My child has a symptom(s) of a physical problem and I want to see if chiropractic will enable their body to work better.

If you checked box 2, fill out CURRENT HEALTH section below. If you checked box 1, skip to Health Survey.

What present complaint or persistent health challenge brings your child to our office?

Has your child had this type of problem before? YES NO Date of Onset: _____

If yes, how so? _____

Have they seen anyone else for this problem? If so, how was it managed including medication?

How is this affecting your life and theirs? _____

Health Survey: Check off any of the following symptoms your child has ever had.

- | | | |
|--|--|--|
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Insomnia/sleep problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue/poor sleep | <input type="checkbox"/> Irritability/Anxiety | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Misbehaviour | <input type="checkbox"/> Digestive trouble | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Asthma/Respiratory issues | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor focus/concentration | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Repetitive motion |
| <input type="checkbox"/> Muscle Stiffness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Hyper/hyposensitivity | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Colds/flu |
| <input type="checkbox"/> Poor motor control | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Toe walking |
| <input type="checkbox"/> Other _____ | | |

Which of the above do you notice the most and how long has it been going on? _____

Physical Stress or Challenges

History of Birth Born at: Home Hospital Birthing Centre Duration of gestation: _____ wks

Was birth assisted? Yes No If yes, How? Forceps Vacuum C-section Induced

Were medications given to the mother or baby at birth? Yes No If yes, what? _____

APGAR score at birth : _____ APGAR score after 5 minutes: _____

Child's birth weight _____ Child's birth height _____

Current Weight: _____ Current height _____

Please describe any childhood illnesses, hospitalizations, surgeries, serious falls, car accidents:

Average number of hours of TV/Computer per week? _____ hrs Weight of school backpack? _____ lbs

Approx. hours spent playing per week? _____ hrs Does your child play sports? Yes No

Chemical Stress or Challenges

During pregnancy, did the mother:

Smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Become ill?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drink alcohol or take drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Receive ultrasounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is your child currently taking any medication (over the counter and/or prescription)?

Allergies or sensitivities? _____

Previous medications: _____

Is/was your child breastfed or formula fed? How long? _____

Any difficulties with latching or breastfeeding? Yes No If yes, explain _____

Is/was your child able to latch on both sides equally? Yes No

Does your child consume sugar daily? Yes No

Is your child exposed to cigarette toxins daily? Yes No

Has your child received any antibiotics? Yes No

If yes, how many times and list reasons why: _____

Did your child receive any vaccinations? Some All None Any reactions?

How often is your child sick? _____

Please list any foods/juice intolerance: _____

Emotional Stress or Challenges

List any emotional/mental stressors presently in your child's life and any previous major stressors. (i.e. parents divorcing, bullying, bedwetting etc.)

Does your child have any behavior problems? Is so, have they been diagnosed?

Goals

In your opinion, does your child seem normal for their age? YES NO

If no, please explain _____

What would you like your child to gain from chiropractic care? _____

Are there other health concerns or anything else you'd like us to know about your child?
