Newcastle Family Chiropractic
10 King Ave East
Newcastle ON. L1B1H6
905-987-9900

Pediatric (0-6 Years) New Patient Intake Form

Child's Name:_____ **Date:**_____

Home Phone #:_____ **Parent's Cell Phone #:**_____

Home Address:_____ **City:**_____ **Postal Code:**_____

Medical Doctor:_____ **Parent's Email:**_____

Child's Gender: Male_____ **Female**_____ **Age:**_____ **Birth Date:**_____

Parent's Names:_____

Sibling's Names and Ages:_____

Does your child have Extended Health Care? N or Y: ____Chiropractic ____Orthotics ____Acupuncture

How did you hear about our clinic? ____Referral ____Doctor ____Website ____Advertising ____Sign

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Present Complaint

What is your child's complaint? Where does your child feel the problem?

_____

_____

When did this start?_____ **How did it start?**_____

Has your child had a similar condition before? N or Y:_____

How frequent is the problem? ____constant ____frequent ____occasional ____comes & goes

What exacerbates/aggravates your child's condition?_____

Do you feel your child's condition is getting: ____worse ____better ____no change

Has your child ever been to a chiropractor before? ____No ____Yes (name):_____

List previous treatments your child has received for this present condition:_____

Developmental History

Has your child ever fallen from high places? _____

Has your child ever been in a motor vehicle accident or near miss? _____

Has your child been ever been to the hospital on an emergency basis? _____

Has your child been vaccinated? N or Y Any adverse reactions? _____

Please "Check" which vaccines your child has received:

____ Diphtheria, Tetanus, Pertussis, Polio
____ Hepatitis B
____ Pneumococcal
____ Measles, Mumps, Rubella
____ Influenza
____ Meningococcal
____ Varicella

At what age did your child crawl? _____ At what age did your child walk? _____

Does your child play any sports? Activities? Hobbies? _____

Please list all medications your child is currently taking:_____

Please list any of your child's medical conditions, surgeries and operations: _____

_____

Please list any family medical conditions: (Ie. Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

_____

<u>Child Health History</u>

Please put a "C" beside anything which is <u>CURRENT</u> problem for your baby/child.

Please put a "P" beside anything which was a <u>PREVIOUS</u> problem for your baby / child.

_____ Ear Infections	_____ Chronic Colds	_____ Upper Respiratory Infections
_____ Digestive Problems	_____ Sinus Troubles	_____ Colic
_____ Allergies	_____ Diarrhea	_____ Recurring Fevers
_____ Seizures	_____ Asthma	_____ Food Sensitivities
_____ Constipation	_____ Eczema	_____ Skin Irritations

Has your baby / child experienced any of the following illnesses:

_____ Chicken Pox	_____ Whooping Cough	_____ Mumps
_____ Rubella	_____ Rubeola	

FEE STRUCTURE: It is expected that payment will be made at each office visit or, if you prefer, you may pay in advance. There is a charge for missed appointments if 24 hours notice is not given.

_____	_____	_____
Signature of patient, parent or guardian	Witness	Date

Pediatric Intake (0-2 Years)

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Prenatal Health

Were there any pregnancy complications? _____

Medications during pregnancy: N or Y: _____

Medications during labour / delivery: N or Y:_____

Was the baby full term?_____ **Spontaneous or Induced Labour?**_____

What was the baby's position at birth? _____

Was the delivery vaginal or C-section? _____

How long was labour? _____ **Pushing Phase?** _____

Were there any delivery complications? _____

Were any special procedures needed for delivery? _____

Medications during pregnancy: N or Y: _____

Medications during labour / delivery: N or Y:_____

Was the baby full term?_____ **Spontaneous or Induced Labour?**_____

Neonatal Health

Birth Weight: _____ **Birth Length:** _____ **Head Circumference:** _____

APGAR Score: (1 minute) _____ (5 minutes) _____

Was the baby ever administered to Neonatal Intensive Care? If yes, how long and why? _____

_____

Does your baby breast or bottle feed? _____

If breast feeding how is latch: Painful? Clicking? Bilaterally Symmetrical?_____

If bottle feeding what is in the bottle and why? _____

How many feedings per day? _____ **What is the length of time / amount per feeding?** _____

Does your baby have any issues with weight gain? _____ **Any food sensitivities?** _____

Does your baby have issues with gassiness or spitting up? _____

How many hours does your baby sleep through the night? _____

How many hours does you baby sleep through the day? _____

Does your baby like tummy time? _____ **Preferred sleeping position:** _____

Does your baby frequency arch their head backwards? _____ **Rotate / tilt their head?** _____

Does your baby cry often? N or Y:_____ **Approximately how many hours a day?** _____

_____ _____ _____

Signature of patient, parent or guardian | Witness | Date