IN LINE FAMILY CHIROPRACTIC

920 Yonge Street PO Box 1030
Walkerton, ON N0G 2V0
519-881-3443
www.ilfc.ca

Child Intake Form

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Personal Information

Patient Name: _____ Gender: _____ Birth Date: _____ Weight _____lbs
Address: _____ Province: _____ Postal Code:_____
Home Phone: _____ Cell: _____ Parent's Work Number: _____
Name of Parent/Guardian: _____
Email address: _____
How did you hear about our office? ☐ Google ☐ You-Tube ☐ FaceBook ☐ lecture/program/event
☐ office website ☐ drive/walk by ☐ current patient _____ ☐ other _____

Reason(s) for visit: _____
Other doctors seen for this Condition: ☐ Yes ☐ No Doctor(s) name: _____
Prior Treatments: _____
Other health problems: _____
Previous Chiropractic Care? _____ Date of last Visit: _____
Reason: _____
Name of medical doctor: _____ Date of last visit: _____
Reason: _____

Prenatal History

Any accidents or fall during the pregnancy? _____
Complications during pregnancy? (pre-eclampsia, excessive weight gain, sugar or other problems) ☐ Yes ☐ No
List:_____
Ultrasounds during pregnancy? ☐ Yes ☐ No Number: _____
Medications during pregnancy/delivery? ☐ Yes ☐ No List: _____
Cigarette/Alcohol use during pregnancy? ☐ Yes ☐ No _____
Complications during delivery? ☐ Yes ☐ No List: _____
Genetic disorders or disabilities? _____

Birth:

Length of labour_____
Birth Intervention: ☐ forceps ☐ vacuum extraction ☐ caesarean section: ☐ emergency or ☐ planned?
Location of birth: ☐ hospital ☐ home ☐ birthing centre
Any unusual skull shape? _____
Were your child's head, neck, arms or legs being held in any unusual position? _____

Feeding History:

Breast fed: ☐ Yes ☐ No How long? _____ Formula fed: ☐ Yes ☐ No How long?_____
Introduced to solids at: _____months Milk at _____months Type of milk_____
Food/Juice Allergies or Intolerances: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Crawl: _____ Sit independently: _____ Stand: _____ Walk: _____
Did your child respond to sound and follow objects well? _____
Did your child gain and grow satisfactorily? _____

Has your child had any major falls? ☐ Yes ☐ No
From heights? (ex. off a bed, change table, down stairs?)_____
Did they land on their head? ☐ Yes ☐ No
Is or has your child been involved in any high impact or contact sports? (ex., soccer, football, gymnastics, martial arts, etc.) ☐ Yes ☐ No Please List: _____
Has your child ever been in a car accident? ☐ Yes ☐ No Details: _____
Other Traumas not listed above? _____
Prior Surgery? ☐ Yes ☐ No Details: _____

Childhood Diseases:

☐ Chicken Pox ☐ Mumps ☐ Rubella ☐ Whopping Cough ☐ Rubeola Other_____

Has this child ever suffered from any of the issues listed below?

☐ Dizziness	☐ Backaches	☐ Heart Trouble	☐ Chronic Ear Earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Cold/Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar Concentration	☐ Behavioural Problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle Jerking
☐ Fainting	☐ Walking problems	☐ Broken Bones	☐ Ruptures/Hernia
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ Joint Problems

Further Comments: _____
_____
_____
_____
_____

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Child's Name: _____ Date: _____

PARENTAL INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

There are risks and possible risks associated with chiropractic examinations used by Doctors of Chiropractic and their staff. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.

I acknowledge that if I choose not to consent to all and/or part of the examination I will have ample opportunity to discuss with the doctor further options. I also understand that without a thorough examination, no treatment will be provided to my child. I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic examination in general, options and recommendations in particular for my child's condition.

_____	_____	_____
Mom - Signature	Dad - Signature	Witness Signature

If shared parenting, do you have sole authority for children's health decisions? ☐Yes ☐No _____ (initials)