



**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: _____ 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 Whooping Cough Rubeola Other _____

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

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