ActiveLiving chiropractic

p: 250.448.8008
f: 250.448.7428

565 Osprey Avenue
Kelowna, BC V1Y 5A7
www.kelowna-chiro.com

Name _____ **Phone** (home) _____

Birthdate _____(month / day / year) (cell) _____

Address _____ (work) _____

_____ **Email** _____

Postal Code _____ Would you like: □ email reminders □ phone reminders

How did you hear about our clinic? □ Friend_____ □ Doctor_____ □ Maternal Health Nurse

□ Other Professional_____ □ Yellow Pages □ Sign □ Website □ Other:_____

Mother's Name	*Occupation*	*City*	*Work Phone*
Father's Name	*Occupation*	*City*	*Work Phone*

CURRENT CONDITION:

What concerns do you have regarding the health of your child?_____

_____When did it start?_____

List other professionals seen for this:_____

HEALTH HISTORY AND INFORMATION

PREGNANCY

Did you require medication through your pregnancy? Yes / No (describe)_____

Were there any complications through your pregnancy? Yes / No (describe)_____

BIRTH

The birth and delivery of your child can give vital clues to potential spinal problems. Please answer the following questions

Home / Hospital / Birth Center Delivery Drugs During Delivery Yes / No (describe) _____

Vaginal Delivery Yes / No Caesarean Yes / No Chemically Induced Yes / No

Breech Yes / No Posterior Yes / No

Suction Yes / No Forceps Yes / No

At Term Yes / No Premature Yes / No _____weeks Late Yes / No_____weeks

Other: _____

Birth Weight _____Current Weight _____Height/Length _____

Length of Labour _____hrs Length of Delivery_____min/hrs Baby's APGAR score _____

Do you believe the birth was traumatic for your child? Yes / No (describe)_____

Was your child's head misshapen at birth? Yes / No (describe)

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Were there any delivery complications? Yes / No (describe)_____

BIRTH TO SIX MONTHS

Baby's Feeding Habits : ____ breast (how long? ____months) (were there latching issues? Yes / No (describe))

____ bottle ___ formula (how long? ____months) (type _____)

Current Diet _____

Did your child suffer with colic? Yes / No If yes, how bad was it? Mild Moderate Severe

Did your child suffer with acid reflux? Yes / No If yes, how bad was it? Mild Moderate Severe

Quality of Sleep: Very Poor Poor Average Good Very Good Number of Hours/night _____

Birth trauma, infection, jaundice, etc. _____

Congenital Anomalies/childhood diseases _____

OTHER PROBLEMS

Please indicate by circling any of the following conditions your child has experienced in the past (P) or Current (C)

Headache	(P) (C)	Neck Pain	(P) (C)	Back Pain	(P) (C)
Allergies	(P) (C)	Constipation/Diarrhea	(P) (C)	Earaches/Infections	(P) (C)
Sinus Pain	(P) (C)	Recurrent tonsillitis	(P) (C)	Recurrent chest infection	(P) (C)
Bedwetting	(P) (C)	Growing Pains	(P) (C)	Hyperactivity/ADD	(P) (C)
Loss of appetite	(P) (C)	Poor sleeping habits	(P) (C)	Visual disorders	(P) (C)
Constant fatigue	(P) (C)	Arm/Leg pain	(P) (C)	Recurrent stomach aches	(P) (C)
Scoliosis	(P) (C)	Fever	(P) (C)	Convulsions	(P) (C)
Joint Pains	(P) (C)	Asthma	(P) (C)	Travel sickness	(P) (C)
Night Terrors	(P) (C)	Seizures	(P) (C)	Chronic colds	(P) (C)
Recurring Fevers	(P) (C)	Hip problems	(P) (C)	Digestive Disorders	(P) (C)
Developmental Delay	(P) (C)	Poor social skills	(P) (C)	Extremely messy eater	(P) (C)
Bone Disease	(P) (C)	Anemia	(P) (C)	Diabetes	(P) (C)

Other: _____

SCHOOL AGE CHILDREN:

Poor co-ordination	Learning difficulties	Poor hand writing
Behavioral Issues	Diagnosed as ADD/ADHD	Delayed verbal communication
Diagnosis of Autism	Difficulty with reading / writing / spelling	Extreme clumsiness

Other: _____

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MEDICAL HISTORY

Medical Practitioner's Name _____Phone_____Date last seen _____ Reason for visit/comments _____

What age did your child begin crawling? _____Months How long did your child crawl for?_____Months

Is your child accident-prone? Yes / No Has your child had any significant falls? Yes / No

Please describe any falls or accidents your child has had:_____

Has your child ever been involved in a motor vehicle accident? Yes / No

Has the child been on antibiotics yet? Yes / No If yes, In last 6 months Yes / No In lifetime _____times

Current Medications/Vitamins_____

Immunization/Vaccinations_____

Has your child had any diseases/illnesses? Yes / No (details) _____

Has your child ever been hospitalized or had surgery? Yes / No (details) _____

Has your child ever had any broken bones or sprain injuries? Yes / No (details) _____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous Chiropractic care? Yes / No

Reason for care:_____

Date of last care: _____/_____/_____ Location:_____ Name of Chiropractor: _____

Were X-Rays taken Yes / No How would you describe the care received? Excellent Good Fair Poor

Further Comments:_____

FAMILY HISTORY

Please state **who** has/had condition (eg. maternal grandma), **how old** they were when **diagnosed**, & **what type** (eg. Lung CA). Have they passed away?

Cancer (Type) _____Diabetes_____Stroke_____

Heart disease _____Kidney disease _____Mental illness_____Seizures_____

Autoimmune disorder_____Other:_____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**