TAILOR MADE WELLNESS CLINIC

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www.tailormadewellness.com

CHIROPRACTIC
Pediatric Intake Form
(2 – 12 years)

Alberta Healthcare # (required for clinic paperwork purposes)	

Personal Information

Name			Date
Address			
City, Province			Postal Code
Home Phone.			OK to leave messages? ☐ Yes / ☐ No
Birth Date:		Gender:	
Age:	Height:	Weight:	☐ Right handed / ☐ Left handed

Emergency Contact Information

Mother's name:	
Home phone:	Work phone:
Father's name:	
Home phone:	Work phone:
Other/Legal guardian:	Relationship:
Home phone:	Work phone:
Name of family doctor:	

Medications (Please list medication names where possible.)

☐ Antibiotics	☐ Antidepressants	☐ Bronchodilators (Asthma)
☐ Birth control	☐ Muscle relaxants	☐ Cold medication

☐ Anti-inflammatories / Pain killers
- ☐ *Aspirin / ASA (acetylsalicylic acid) Bufferin*
- ☐ *Advil / Ibuprophen*
- ☐ *Tylenol / Anacin / Acetominophen*
- ☐ *Corticosteroids (prednisone, asthma drugs, etc.)*
- ☐ *Robaxin / Robaxisal / Robaxacet / Robax Platinum, etc.*

☐ Non-prescription/recreational ☐ Other

☐ I am currently not taking any medications

Vitamins / Herbs / Supplements (Please list all.)	Allergies (Please list.)

Primary concern

What is your child's <u>primary concern</u> today?

Date of onset/duration?

Is this a Motor Vehicle Accident Case? ☐ Yes / ☐ No

TAILOR MADE WELLNESS CLINIC **Chiropractic Pediatric Intake Cont'd**

General Health History		
Recently has your child awakened complaining of pain?	☐ Yes / ☐ No	
Has there been a recent change in the child's energy level?	☐ Yes / ☐ No	
How would you describe your child's health?	☐ Robust	☐ Poor
	☐ Good	☐ Sickly
	☐ Average	
Are you concerned with any of the following?	☐ Constipation	☐ Diarrhea
	☐ Bed wetting	

Did your child have any prior health problems that have been corrected or outgrown?
☐ Yes / ☐ No If yes, please explain:

Have you ever been told your child has unusual skeletal changes ☐ Yes (Describe?) / ☐ No
(eg: scoliosis, unusual vertebra, short leg, etc.?)

Please check all additional concerns that apply:	**How long?**		**How long?**
☐ Headaches / Migraines		☐ Arm/hand pain, numbness, tingling	
☐ Neck pain, soreness or stiffness		☐ Chest wall pain	
☐ Upper back pain, soreness, stiffness		☐ Shoulder pain	
☐ Lower back pain, soreness, stiffness		☐ Leg/foot pain, numbness, tingling	
☐ Hip / groin pain		☐ Other	

Is your child showing signs of having?	☐ Asthma	☐ Allergies
	☐ Recurrent infections	

Has your child ever been treated by a Chiropractor for any condition? ☐ Yes (When?) / ☐ No

If yes, Doctor's name: Were treatments helpful? ☐ Yes / ☐ No

Name of family doctor:

Sports involvement			
☐ Badminton	☐ Golf	☐ Music (instrument:)	
☐ Baseball	☐ Gymnastics	☐ Soccer	☐ Weight lifting
☐ Basketball	☐ Hockey	☐ Swimming	☐ Wrestling
☐ Dancing	☐ Horse riding	☐ Tennis	☐ Other
☐ Figure skating	☐ Martial arts	☐ Track & field	
☐ Football	☐ Ringuette	☐ Volleyball	

Injuries / History

Have you noticed any unusual shoe wear? ☐ Yes / ☐ No

Has your child been fitted for orthotics? ☐ Yes / ☐ No Is he/she wearing them now? ☐ Yes / ☐ No

Do you have any concern regarding your child's walking patterns? ☐ Yes / ☐ No

Do you have any concern regarding your child's posture? ☐ Yes / ☐ No

Has your child ever broken any bones? ☐ Yes / ☐ No If yes, please list:

Has your child ever had a fall that required chiropractic or medical attention? ☐ Yes (When?) / ☐ N

Has your child ever been knocked unconscious? ☐ Yes (When?) / ☐ No

Has your child ever been involved in a motor vehicle accident? ☐ Yes (When?) / ☐ No

Have you ever been told you have unusual skeletal changes ☐ Yes (When?) / ☐ No
(eg: scoliosis, unusual vertebra, short leg, etc.?)

Did you have any prior health problems that have been corrected or you've outgrown?
☐ Yes / ☐ No If yes, please explain:

Name: _____ Age _____ Date _____ Score _____

Score: #1 + #2 + #3 + #4 = / 3 x 10= (Low intensity = < 50. High intensity = > 50.)

Signature

Parent/Guardian signature: