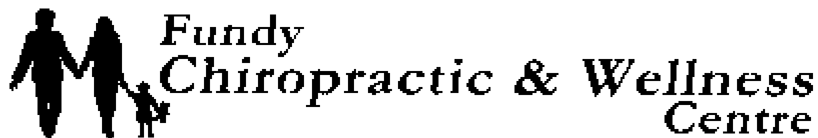

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PEDIATRIC ENTRANCE FORM

Child's Name__________________________ Date___________________________

Parents' Names________________________ _______________________________

Marital status of parents____

Are you legally entitled to consent to this child's healthcare? _______ YES ________ NO

Siblings' Names (ages)____

Address____

City______________________ Prov..________ Postal Code_______________

DOB_____________________ Age_________ Tel ______________________

Referred By____

Has your child ever received chiropractic care? ____**YES** _____**NO**

If yes, previous doctor's name and date of last visit_____________________________

Name of Medical Doctor ____

Date of last doctor visit and reason ____

Present Health Complains/Concerns

Major____

Minor____

When did this problem begin?____

Is this problem (circle) **occasional** **frequent** **constant** **intermittent**

Does this problem radiate? ___YES ____NO If yes, where?_________________________

What makes this worse?____

What makes this better?____

Is the problem worse during a certain time of the day? ____**YES** ____**NO**

If yes, when?____

Does this interfere with the child's _______Sleep _____Eating _______Daily Routine

Is this becoming worse?____

Other professionals seen for this condition_______________________________________

Results with that treatment____

Often seemingly unrelated symptoms can manifest as other health concerns:
(please circle if your child has had any of the following)

Headaches	Loss of taste	Weight gain	Upper back pain
Dizziness	Light sensitivity	Dental problems	Neck pain
Fainting	Face flushed	Fevers	Low back pain
Irritability	Bronchitis	Chest pressure	Stiffness
Depression	Pneumonia	Breast Pain	Reduced Mobility
Loss of balance	Difficulty breathing	Frequent colds	Numbness in leg(s)
Loss of concentration	Shortness of breath	Sinus congestion	Numbness in feet
Loss of memory	Asthma	Sore throat	Numbness in hand(s)
Ear buzzing	Urinary problems	Ear infection/pain	Weakness
Poor coordination	Constipation	Allergies	Muscle cramps
Vision changes	Diarrhea	Heartburn	Sleeping problems
Loss of smell	Weight loss	Bloating	Gas

Other?____

History of Birth

What was the child's gestational age at birth?___________weeks

Birth Weight__lbs____oz Birth Length ______inches

Was your child born (circle) **at home** **in a birthing center** **in a hospital**

Was the birth considered (circle) **medical** **midwife**

What was the duration of the labour and birth?__________hours

Was the child born **cephalic (head first)** **breech (feet first)**?

Were there any complications? **YES** **NO**

If yes, please explain____

Please circle any assistance which was used during the birth

Forceps **Vacuum extraction** **C-section** **Episiotomy**

Was labour (circle) **spontaneous** or **induced**

Were any medications or epidurals given to the mother during birth? **YES** **NO**

If yes, what was given?____

Apgar score (if known): at birth______/10 after 5 minutes____________/10

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? **YES** **NO**

If no, please explain____

At what age did the child

Respond to sound	____________	Follow an object	____________
Hold up head	____________	Vocalize	____________
Sit alone	____________	Teethe	____________
Crawl	____________	Walk	____________

Do you consider the child's sleeping pattern normal? **YES** **NO**

If no, please explain____

Family Health History

Please note any health problems

Mother's family____

Father's family____

Siblings____

Since problems that chiropractors look for can be related to many types of stressors, the following information is also very important to us:

Physical Stressors

Any trauma to the mother during pregnancy? (falls, accidents, etc.) **YES** **NO**

Please explain____

Any evidence of birth trauma to the infant? (Please check)

______ **Bruising**

______ **Respiratory depression**

______ **Fast or excessively long birth**

______ **Stuck in birth canal**

______ **Odd shaped head**

______ **Cord around neck**

Any falls from couches, beds, change tables, etc.? **YES** **NO**

If yes, please provide details____

Any traumas resulting in bruising, cuts, stitches or fractures? **YES** **NO**

If yes, please provide details____

Any hospitalizations or surgeries? **YES** **NO**

If yes, please provide details____

Any sports played? ____

Is a school backpack used? **YES** **NO**

If so, is it **heavy** or **light**

Chemical Stressors

Was the child breast fed? YES NO

If yes, how long?______________________

Formula introduced at what age?_________ What formula?______________________

Introduction of cow's milk at what age?_______

Began solid foods at what age?__________ Types of foods?______________________

Any food or juice intolerance? YES NO

Type of intolerance?______________________________________

During pregnancy did the mother **Smoke?** **YES** **NO** How much?______________________

Drink? **YES** **NO** How much?______________________

Any illnesses during the pregnancy? **YES** **NO**

If yes, please explain____

Any supplements taken during pregnancy? **YES** **NO**

If yes, please list ____

Any Ultrasounds? **YES** **NO**

How many and reasons for being done?____

Any invasive procedures during pregnancy (amniocentesis,surgery, etc.)? **YES** **NO**

If yes, please explain____

Any pets at home? **YES** **NO** List______________________________

Any smokers in the home? **YES** **NO**

Vaccinations and age given____

Any negative reactions? **YES** **NO**

Please explain____

Any antibiotics given? **YES** **NO**

Reason____

Psychosocial Stressors

Any difficulties with lactation? **YES** **NO** ___________________

Any problems with bonding? **YES** **NO** ___________________

Any behavioral problems? **YES** **NO** ___________________

Any night terrors, sleepwalking, difficulty sleeping? **YES** **NO** ___________________

Age when child began daycare ___________

Average number of hours of TV per week ________

Average number of hours of computer use/gaming/etc. per week_______

Do you feel that your child's social and emotional development is normal for their age? **YES** **NO**

If no, explain ____

Additional Comments

____

____

Signature:____**Date:**___________________________