STONEBRIDGE CHIROPRACTIC

PEDIATRIC CHIROPRACTIC INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Child's Name (first/last): _____ Middle Initial: _____ Sex: _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Sask Health Card #: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Email: _____

Cell #: _____ Home #: _____ Work #: _____

Family Doctor: _____

Emergency Contact (Name & Phone Number): _____

Referred By: _____ Referred To: _____

Mother's Name: _____ Father's Name: _____

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments
_____ Emailed reminders 24 hours prior to appointments
_____ Text reminders 24 hours prior to appointments
_____ Please do not send me any emails/text messages

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients, Chiropractors, and other providers, I understand that I must give 3 hours' notice if I cannot make it to my scheduled appointment. Stonebridge Chiropractic will charge me for missed appointments at the rate of the scheduled visit, billed directly to me, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. _____ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood, and agree to the above financial policies. _____ (Initial)**

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____

PLEASE CONTINUE ON THE OTHER SIDE ⟶

What is your reason for consulting our clinic? _____

_____

_____

Please check any area that applied to the patient's mother during pregnancy:

- Tobacco
- Vitamins/Minerals
- Recreational Drugs
- Alcohol
- Hospitalization
- Immunization
- Bleeding
- High Blood Pressure
- Back Pain
- Premature Contractions
- Prenatal Massage
- Chiropractic Care
- Prenatal Classes
- Prenatal Care
- Carried to Full Term

Were there any complications during the pregnancy or labour?_____

_____

What was the child's birth weight? _____ Length? _____ Current Weight? _____

Apgar score at birth? _____ /_____ Duration of pregnancy in weeks? _____

Does he/she tend to favor one side when nursing? _____

Does the child have any food allergies/sensitivities? _____

How many bowel movements per day? _____ Any obvious discomfort? _____

How many wet diapers per day? _____ Is your child gassy? _____ Hard to burp? _____

LABOUR AND DELIVERY (Please check all that apply):

- Hospital Birth
- Suction Used
- Back Labour
- Late Term Delivery
- Home Birth
- Bleeding
- Epidural
- Fetal Heart Monitor Used: If Yes: Internal / External
- Forceps Used
- Caesarean Section
- Premature Delivery
- Medications Used:_____
- Please list any complications: _____

_____

Did any of the following apply to the patient at birth or soon after (Please check all that apply)?

- Medication
- Surgeries
- Colouring Problems
- Sleeping Problems
- Artificial Feeding
- Silver Nitrate
- Crying
- Nursing Problems
- Vitamin K
- Breathing Problems
- Choking
- Jaundice

NUTRITION:

- Breast Milk
- Formula
- Cow's Milk
- Soy Milk
- Juice
- Vitamins/Supplements
- Other: _____
- Solid Foods: If yes when were they started and what was first introduced: _____
- Medications: Please list: _____

Excessive decrease in weight? Yes / No How much? _____ Reason? _____

Excessive increase in weight? Yes / No How much? _____ Reason? _____

Has your child been involved in any motor vehicle accidents (Please circle)? Yes / No

Injuries/Treatment? _____

Has your child experienced any major falls? _____

Has your child experienced any major infections? _____

Has your child taken any prescription medications or antibiotics? _____

Does your child exhibit any difficulty with movement of the head or body awkwardness? _____

Has your child begun crawling? Walking? At what age? _____

Is your child very physically active? _____

Has your child experienced any of the following?

- Asthma
- Unexplained Crying
- Difficulty Hearing
- Frequent Fevers
- Bed Wetting
- Ear infections (R or L)
- Allergies
- Skin Rashes
- Colic
- Seizures
- Constipation/Diarrhea
- Vomiting
- Excessive Abdominal Pain
- Sinus Infections
- Other: _____

Please list any conditions or illnesses that have already been diagnosed. Including any serious mental or physical traumas for which treatment was recommended and/or received: _____

_____

_____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____