

CHILD INFORMATION AND PRE-CONSULTATION QUESTIONNAIRE

Patient Information

Date:

First Name		Last Name		
Address				
Town/City		Province	Postal Code	
Home Phone		Alternate Phone		
Birth Date	Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Age	Height
Email		Name of Parents or Guardians		
How did you hear about our office?				
Were you referred to this office? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, by whom?				

Health Card Information

Do you have Extended Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	Amount of coverage per year
If yes, by what company?	

History

What is your major complaint?
When did you first notice this condition?
Is this condition getting progressively worse? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Comes and goes
What activities aggravate your condition?
Is this condition interfering with your: <input type="checkbox"/> Exercise <input type="checkbox"/> Sleep <input type="checkbox"/> Daily routine <input type="checkbox"/> Other
Have you seen any other health care professionals for this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who and when?
Have you ever been in a car accident? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please explain, giving date of accident(s) and description of injuries.
Have you ever been knocked unconscious? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever broken any bones? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any other complaints?

Please describe:

Past injuries
Prior surgeries
Prior hospitalizations

Please turn over

Past Medical History

Family Physician	Phone Number	Date of last examination
Have you been treated by a physician for any condition(s) in the past 12 mo.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain		
Number of doses of antibiotics taken during past 6 months: Total during lifetime:		
Number of doses and type of other prescription medication taken during past 6 months: Total during lifetime:		
Vaccination history		
Please list current medications		

Circle any conditions that you have now or have experienced in the past

Ear infections	Sinus trouble	Chronic colds	Bronchitis/Upper respiratory infections	
Asthma	Allergies	Insomnia	Recurring fevers	Headaches
Autism	ADD/ADHD	Nervousness	Anxiety/panic disorders	
Growing pains	Colic	Skin conditions	Digestive problems	
Neck pain	Midback pain	Lower back pain	Constipation	Diarrhea
Siezuers	Scoliosis	Bed wetting	Other	

Previous care

Have you ever had chiropractic care in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Doctor seen	Date of last treatment
Have you ever had x-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list herbal or vitamin supplementation	
Are you involved in any high impact or contact type sports? <input type="checkbox"/> No <input type="checkbox"/> Yes List:	
How often do you exercise?	
What type of exercise?	
Start of menstrual cycle? <input type="checkbox"/> No <input type="checkbox"/> Yes Age:	

Birth History

Complications during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes List:		
Medications during pregnancy/delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes List:		
Complications during delivery? <input type="checkbox"/> forceps <input type="checkbox"/> vacuum extraction <input type="checkbox"/> c-section emergency or planned <input type="checkbox"/> induced labour		
Genetic disorders or disabilities? <input type="checkbox"/> No <input type="checkbox"/> Yes List:		
Birth weight:	Birth length:	Apgar scores normal/abnormal