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 ☐ M ☐ F	Age	Height	Weight
Email	Name of Parents or Guardians			
How did you hear about our office?				
Were you referred to this office? ☐ No ☐ Yes If so, by whom?				

Health Card Information

Do you have Extended Health Insurance? ☐ No ☐ 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? ☐ No ☐ Yes ☐ Comes and goes
What activities aggravate your condition?
Is this condition interfering with your: ☐ Exercise ☐ Sleep ☐ Daily routine ☐ Other
Have you seen any other health care professionals for this condition? ☐ No ☐ Yes If yes, who and when?
Have you ever been in a car accident? ☐ No ☐ Yes
If yes, please explain, giving date of accident(s) and description of injuries.
Have you ever been knocked unconscious? ☐ No ☐ Yes
Have you ever broken any bones? ☐ No ☐ 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.? ☐ Yes ☐ 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
Siezures	Scoliosis	Bed wetting	Other	

Previous care

Have you ever had chiropractic care in the past? ☐ No ☐ Yes	
Doctor seen	Date of last treatment
Have you ever had x-rays taken? ☐ Yes ☐ No	

Please list herbal or vitamin supplementation
Are you involved in any high impact or contact type sports? ☐ No ☐ Yes List:
How often do you exercise?
What type of exercise?
Start of menstrual cycle? ☐ No ☐ Yes Age:

Birth History

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