CHILD PATIENT INTRODUCTION
SCHOOL AGED (6-17 years)

Full Name: ____ Date: __________________
FIRST MIDDLE LAST YYYY / MM / DD

Mailing Address ____
STREET CITY PROVINCE POSTAL CODE

Birthdate: __________________ Age: _______ Height: _______ Weight: _______ ❑ Male ❑ Female
YYYY / MM / DD LBS.

Alberta Health Care #: ______________________________ ❑ My Child does not have AHC Coverage

Mother and/or Father's Name: __________________________ Home Phone #: __________________

Mother and/or Father's Occupation: _______________________ Work Phone #: __________________

Number and Ages of Siblings: Brothers: # ______ Ages: __________ Sisters: # ______ Ages: __________

We were referred by: ❑ FRIEND / RELATIVE ❑ DOCTOR ❑ PHONE BOOK ❑ SIGN

If you were referred by a doctor, friend or relative, please give their name: __________________________

Present MD? ____________________ Date of last MD Visit and reason: ________________________

Has your child previously seen a chiropractor? ❑ SINCE JULY 1 ❑ OVER A YEAR AGO ❑ NEVER

Who did your child see? ____

Describe your child's main health concern: ____

How long has your child had this condition? ____

❑ YES ❑ NO Has your child had these or similar conditions in the past? When? __________________

What activities aggravate your child's condition? ____________________________

Is this condition getting worse? ❑ YES ❑ NO ❑ Or is it CONSTANT

❑ YES ❑ NO Is this condition interfering with any of your child's daily activities? Check all that apply:

❑ PLAY ❑ SLEEP ❑ DAILY ROUTINES ❑ OTHER _______________________

❑ YES ❑ NO Any Hospitalizations? Explain: ____

❑ YES ❑ NO Vitamins/ Nutritional supplements? Type: ____________________________________

❑ YES ❑ NO Is your child currently taking any Medications? Type:____________________________

Please list any surgeries your child has had and the date(s): ____________________________________

Has your child ever been in an auto accident? ❑ NEVER ❑ PAST YEAR ❑ LAST 5 YEARS ❑ OVER 5 YEARS

Describe: ____

❑ YES ❑ NO Has your child had any other major illnesses in the past? ________________________

❑ YES ❑ NO Any MAJOR health problems in the immediate family (Cancer, Disease, Diabetes, Etc.)?

Please List: ____

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(Please answer YES or NO to each question and provide details where necessary)

IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING:

YES	NO	
❑	❑	Back or Neck Pain? ______
❑	❑	Pain in the arms or legs? ______
❑	❑	Headaches? ______
❑	❑	Asthma? ______
❑	❑	Allergies? ______
❑	❑	Earaches? ______
❑	❑	Falls from a bicycle, skateboard, roller blades or similar? ______
❑	❑	Have you ever had a problem with bed-wetting? ______
❑	❑	Have you ever had any broken bones? ______
❑	❑	Do you have any other health problems? ______

ABOUT YOUR LIFESTYLE

What sports/hobbies do you do? ______

How heavy is your school book bag? ______

How do you carry your school books? ______

On average, how many hours of sleep do you get each night? ______

How many hours a day do you spend on the Computer? ______ T.V? ______

❑ YES ❑ NO Are there any smokers in your family? ______

❑ YES ❑ NO Do you feel stressed out? ______

❑ YES ❑ NO Do you have trouble reading the board in class? ______

❑ YES ❑ NO Do you wear glasses or contact lenses? ❑ Glasses ❑ Contact Lenses ❑ Both

❑ YES ❑ NO Do you sometimes get headaches when you read? ______

ABOUT YOUR DIET

What do you usually eat for breakfast? ______________________________

What do you usually eat for lunch? ______________________________

What do you usually eat for dinner? ______________________________

What snacks do you have after school? ______________________________

What is your favorite food? ______________________________

How much water do you drink each day? ______________________________

How many sodas or colas do you drink each day? ______________________________

How often do you eat fast food items? ______________________________

Any other information you think the doctor should know? ______________________________

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