16945 Leslie St
Unit 17
Newmarket, ON
L3Y 9A2

Tel: 905.898.8098
Fax: 905.898.8099

FosterFamilyChiropractic
& ASSOCIATES

CHIROPRACTIC PEDIATRIC INTAKE FORM

When complete, please bring this form with you to your first appointment.

Patient Information

First Name ______________________ Last Name ______________________

Street Address ______________________ Apartment __________

Town/City ______________________ Province __________ Postal Code __________

Home Phone ______________________ Work Phone ______________________

Cell ______________________ E-Mail ______________________

Birth Date ______________________ Age __________ Sex __________

Height __________ ☐ cm ☐ in Weight __________ ☐ kg ☐ lbs

Names of Parents / Guardians ______________________

How did you hear about our office? ______________________

Were you referred to this office? ☐ Yes ☐ No

If yes, by whom? ______________________

Health History

Purpose of contacting us? ______________________

How long has your child experienced this? ______________________

Is it getting better or worse over time? ☐ Better ☐ Worse

Name of your medical doctor ______________________ Date of last visit __________

Other health care professionals consulted for this problem ______________________

____

Other health problems? ______________________

Select any of the following that you are experiencing now or have experienced in the recent past:

- ☐ Ear Infections
- ☐ Asthma / Allergies
- ☐ Colic
- ☐ Allergies
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Growing Pains
- ☐ Back Pains
- ☐ Eczema / Skin Problems
- ☐ Constipation / Diarrhea
- ☐ Neck Pains
- ☐ Bronchitis / Upper Respiratory Infections
- ☐ Temper Tantrums
- ☐ ADD / ADHD
- ☐ Other Specify Other ______________________

Are you content with your child's present level of health? ☐ Yes ☐ No

Please explain ______________________

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Previous Chiropractor ____

Reason for Visits ____

Has your child been treated by a physician for any condition in the previous 12 months? ☐ Yes ☐ No

If yes, please explain ____

Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list along with reason ____

Has you child taken any medication for an extended period of time in the past? ☐ Yes ☐ No

If yes, please list along with reason ____

Does your child take any herbal or vitamin supplementation? ☐ Yes ☐ No

If yes, please list ____

Number of doses of antibiotics your child has taken:

During the past 6 months ________________ During his/her lifetime ________________

Number of doses of other prescription medications your child has taken:

During the past 6 months ________________ During his/her lifetime ________________

List: ____

Has your child received vaccinations? ☐ Yes ☐ No

Does your child exercise? ☐ Yes ☐ No

What type of exercise? ____

Prenatal History

Name of Midwife / Obstetrician ______________________________ Ultrasound during pregnancy? ☐ Yes ☐ No

Medication during pregnancy? ☐ Yes ☐ No

Medication during labour / delivery? ☐ Yes ☐ No

If yes, please list ____

Were you induced? ☐ Yes ☐ No

Was your child at any time during your pregnancy in an intra-uterine constraining position such as:

☐ Breech ☐ Transverse Lie (side lying) ☐ Face / Brow Presentation

Was your delivery vaginal? ☐ Yes ☐ No

Was your delivery C-Section? ☐ Yes ☐ No

If so, was it planned or emergency? ☐ Planned ☐ Emergency

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Were there any of the following used during delivery? ☐ Forceps ☐ Vacuum Extraction ☐ Other

If other, list ____________________

Any complications during delivery? ☐ Yes ☐ No

If yes, explain ____________________

Location of birth ☐ Hospital ☐ Birth Centre ☐ Home

Weight __________ ☐ kg ☐ lbs Length __________ ☐ cm ☐ in

Feeding History

Breast Fed: ☐ Yes ☐ No

If so, how many months? __________

Formula Fed: ☐ Yes ☐ No

If so, type? ____________________

Introduced to solids at: __________ months Cow's milk at __________ months

Food Sensitivities ____________________

Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

Hold head up __________ Sit Up __________ Cross Crawl __________

Walk Alone __________

Has your child ever fallen from a high place? (bed, change table, sofa, down stairs, etc.) ☐ Yes ☐ No

If yes, please explain ____________________

Is / was your child involved in any impact or contact sports? ☐ Yes ☐ No
(soccer, football, gymnastics, baseball, roller or ice hockey)
If yes, please explain ____________________

Has your child ever been involved in a car accident? ☐ Yes ☐ No

If yes, please explain ____________________

Has you child ever been seen on an emergency basis? ☐ Yes ☐ No

If yes, please explain ____________________

Other traumas? ☐ Yes ☐ No

If yes, please explain ____________________

Prior surgery? ☐ Yes ☐ No

If yes, please explain ____________________

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Childhood Illnesses

Please indicate if your child has experienced any of the following illnesses, and if so, at what age (year).

☐ Chicken Pox Age ___________ ☐ Mumps Age ___________ ☐ Rubella Age ___________
☐ Whooping Cough Age ___________ ☐ Rubeola Age ___________ ☐ Other Age ___________
If other, please list ____

Additional Comments

____
____
____

CONSENT for examination: Please Reads Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I understand that I can at any time discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name:____ **Date:** ________________________

Signature:__________________________________ **Witness:**_______________________________

Doctor of Chiropractic:

Please complete this form prior to arriving at our office. If you have any questions, please do not hesitate to contact our office at 905-898-8098, or wait until your appointment time. We are excited that you have chosen Dr. Laura Foster & Dr. Danielle Warner for your chiropractic care. It is our pleasure to welcome you and your family to the most natural form of health care, chiropractic.

Instructions for First Appointment

Our office utilizes the most advanced form of non-invasive diagnostic procedures available. Please refrain from intense exercise 6 hours prior to your appointment time, as well as avoiding heat/ice, caffeine and over-the-counter (non-prescription) medications. These may interfere with the quality of your diagnostic results. Please call if you have any questions. We look forward to seeing you.