Fall River Chiropractic Infant New Patient

FALL RIVER CHIROPRACTIC

Date: _____

Child's Name: _____ **DOB:** _____ **Sex:**_____

Address: _____ **City:**_____

Province: _____ **Postal Code:** _____ **Health card number:** _____

Mother's name: _____ **Cell:** _____ **Work phone:** _____

Father's name: _____ **Cell:** _____ **Work phone:** _____

Birth Weight: _____ **Birth Length:** _____ **Current Weight:** _____ **Current Length:** _____

Reason for today's visit: _____

How did you hear about our office? _____

Third Trimester Presentation (please circle one)

Vertex **Breech** **Transverse** **Face/Bow**

Type of Birth (please circle one)

Normal/ Vaginal **Forceps** **Cesarean** **Suction Cap/ Vacuum**

Location (please circle one)

Home **Hospital**

Problems during pregnancy: _____

Problems during Labour/Delivery: _____ **Apgar Scores:** _____ _____

Was there presence at birth of (please circle one)

Jaundice (Yellow) **Cyannosis (Blue)** **Congenital Anomalies/Defect**

If yes, Please Explain_____

Infant Feeding (please circle one)

Breast **Bottle – If Bottle, Which formula?** _____

Number of Hours Sleeping per night: _____ **Quality of sleep: Good** **Fair** **Poor**

Obstetrician/ Midwife: _____

Pediatrician/ Family MD: _____

Date of last visit: _____ **Purpose:** _____

Immunization History: _____

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Number of doses Antibiotics your child has taken during the past six months: _____

During His/Her lifetime_____

Is your child on any medications_____ If Yes, Please list the Medication: _____

Previous Chiropractor: _____

Date of List Visit: _____Purpose:_____

Has your child ever been treated on an emergency basis? Y / N If Yes, please explain: _____

At what age did your child:

Respond to Sound: _____ Hold head up: _____Respond to visual stimuli: _____

Sit alone: _____ Crawl: _____ Stand: _____ Walk alone: _____

At what age, if ever, did your child ever suffer from the following childhood diseases?

Chickenpox: _____ Mumps: _____Measles: _____Rubella:_____ Rubeola: _____

Whooping cough: _____ other: _____

Has your child ever sustained injuries in an Auto Accident? Y / N

If yes, Please Explain_____

Has your child ever suffered a major fall? Y / N If yes, please explain _____

Has your child ever had surgery? Y / N If yes, Please explain_____

Has your child ever suffered from (please check all that apply)

- **Headaches**
- **Dizziness**
- **Fainting**
- **Seizures/Convulsions**
- **Heart trouble**
- **Chronic earaches**
- **Poor posture**
- **Hypertension**
- **Broken bones**
- **Orthopedic problems**
- **Neck problems**
- **Arm problems**
- **Leg problems**
- **Joint problems**
- **Backaches**
- **Diabetes**
- **Colds/flu**
- **Walking trouble**
- **Bed wetting**
- **Digestive Disorders**
- **Poor appetite**
- **Stomach aches**
- **Reflux**
- **Constipation**
- **Diarrhea**
- **Asthma**
- **Anemia**
- **Behavioral problems**
- **ADD/ADHA**
- **Raptures/Hernia**
- **Muscle pain**
- **Growing pains**
- **Sinus Trouble**
- **Scoliosis**
- **Colic**

Please list any allergies: _____

AUTIORIZATION FOR CARE OF MINOR

I HEARBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF A PARENT/GUARDIAN)

SIGNED: _____ DATE: _____

PLEASE PRINT: _____