FALL RIVER
COLLABORATIVE HEALTH CARE

Child Initial Chiropractic Form

Name: _____
Last Name First Name Middle Initial Pronouns (He/She/They

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal Code

Medical Doctor: _____ Health Card Number: _____

Parent 1/Caregiver Name and Number: _____

Parent 2/Caregiver Name and Number: _____

Parent/Caregiver Email: _____

Chief Complaint

What brings you to our clinic today?
( ) Wellness/preventative care ( ) New pain or injury ( ) Postural issues ( ) Chronic pain/old injury
( ) Other

If other, explain: _____

What is the problematic area? _____

How long has this been an issue? _____

How did the issue start? _____

Has your child ever had this issue before?
( ) yes ( ) No ( ) Unknown

Overall Health

List any medications your child is on and doses if possible:

_____

Has your child ever had any fracture or dislocations?
( ) Yes ( ) No ( ) Unknown

If yes, please explain: _____

Please list any surgeries or hospitalizations:

_____

Immunization history: _____

Has your child ever been in a car accident?
( ) yes ( ) no ( ) Unknown

If yes, explain: _____

Has your child ever had any major traumas or falls?
( ) yes ( ) no ( ) unknown

If yes, Explain: _____

List any sports your child is in, and any injuries sustained during sports:

_____

Has your child ever needed an x-ray?
( ) yes ( ) no ( ) unknown

If yes, explain: _____

Has your child ever had to be seen on an emergency basis?
( ) yes ( ) no ( ) unknown

Has your child ever had/complained of (please check all that apply)
( ) Headaches ( ) Jaw problems ( ) Dizziness ( ) Fainting ( ) Concussions ( ) Seizures/convulsions
( ) Heart trouble ( ) Hypertension ( ) Breathing issues ( ) Asthma ( ) Allergies ( ) Milestone delays
( ) ADD ( ) ADHD ( ) ASD/Autism ( ) Behavioural issues ( ) Neck problems ( ) Back problems
( ) Arm issues ( ) Leg issues ( ) Feet issues ( ) Trouble walking ( ) Balance issues ( ) Joint issues
( ) Scoliosis ( ) Growing pains ( ) Arthritis ( ) Diabetes ( ) Celiac ( ) Reflux ( ) Constipation
( ) Digestive problems ( ) Regular stomach ache ( ) Eating issues ( ) Bed wetting ( ) Ear infections
( ) Multiple doses of antibiotics ( ) Hernia ( ) Anemia ( ) Eczema ( ) Psoriasis
( ) Other skin issues (rashes/infections) ( ) Bruise easily

Does your child have any Health conditions?
( ) Yes ( ) No ( ) Unknown

If yes, explain: _____

Is there any relevant family health history?
( ) Yes ( ) No ( ) Unknown

If yes, explain: _____

Is there anything else we need to know about your child?

_____

Treatment History

Has your child ever been treated by a chiropractor before?
( ) Yes ( ) No ( ) Unknown

If yes, how long ago? _____

Has your child seen any of the following:
( ) Physiotherapist ( ) Naturopath ( ) Acupuncturist ( ) Osteopath ( ) Occupational Therapist
( ) Massage Therapy ( ) Other Specialist

If other, who? _____

Authorization of care for a minor
I HEARBY AUTHORIZRE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF A PARENT/GARDIAN)

I accept
( ) Yes ( ) No