FALL RIVER
COLLABORATIVE HEALTH CARE

Infant Initial Chiropractic Intake

Personal Information

Name: _____
Last Name First Name Middle Initial

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal Code

Family Doctor: _____ Health Card Number: _____

Parent 1/Caregiver Name and Number: _____

Parent 2/Caregiver Name and Number: _____

Parent/Caregiver Email Address: _____

Chief Complaint

What brings you into our clinic today? _____

If there is a specific issue, how long has this been an issue? _____

How did the issue start? _____

Birth History

Third trimester presentation
( ) Breach ( ) Head down (vertex) ( ) Face/brow ( ) Transverse

Type of birth
( ) Vaginal ( ) Forceps ( ) c-section ( ) Suction/vacuum ( ) Unknown

Location
( ) Home ( ) Hospital ( ) Other

Problems during pregnancy:

_____

Apgar score at birth (out of 10): 1 2 3 4 5 6 7 8 9 10

Did your child have any of the following:
( ) Jaundice ( ) Cyanosis (blue colouring from lack of oxygen)
( ) Congenital anomalies or birth defects

Infant Feeding:
( ) Breast ( ) Formula ( ) Both

Discuss any feeding issues: _____

How is their sleep?
( ) Excellent ( ) fair ( ) Poor

Discuss any sleeping issues or concerns:

_____

Age your child held up head: _____

Age your child rolled over: _____

Age your child crawled: _____

Age your child walked: _____

Age your child started speaking: _____

Age your child potty trained: _____

Discuss any milestone delays or concerns: _____

Please list any medications your child is on and doses if possible:

_____

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

If yes, explain: _____

Please list any surgeries or hospitalizations:

_____

Immunization History: _____

Has your child ever had any major traumas or falls?
( ) Yes ( ) No ( ) Unknown

If yes, explain: _____

Has your child ever had 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 had any of the following (Please check all that apply)
( ) Headaches ( ) Jaw problems ( ) Dizziness ( ) Fainting ( ) Concussions ( ) Seizures/convulsions
( ) Heart trouble ( ) Hypertension ( ) Breathing issues ( ) Asthma ( ) Asthma ( ) Allergies
( ) Milestone delays ( ) ADD ( ) ADHA ( ) ASD/autism ( ) Behavioural issues ( ) Neck problems
( ) Back problems ( ) Arm issues ( ) Leg issues ( ) Feet issues ( ) Trouble walking ( ) Balance issues
( ) Joint issues ( ) Growing pains ( ) Diabetes ( ) Celiac ( ) Reflux ( ) Constipation
( ) Digestive problems ( ) Regular stomach ache ( ) Eating issues ( ) Ear infections
( ) Multiple doses of antibiotics ( ) Hernia ( ) Anemia ( ) Eczema
( ) 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/is your child seeing any of the following:
( ) Physiotherapist ( ) Naturopath ( ) Acupuncturist ( ) Osteopath ( ) Occupational Therapist
( ) Massage Therapist ( ) Other Specialist

If other, who? _____

Authorization of care for a minor

I HEARBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECEASSARY TO MY SON/DAUGHTER/WARD (UPON APROVAL OF A PATIENT/GAURDIAN)

I accept
( ) Yes ( ) No