Dr Janine Kinahan, Chiropractor, 2740344F
Dr Kathy Johansson, Chiropractor, 4611863J
Dr Sophie Parish, Chiropractor, 5088145L
Dr Todd Daniels, Chiropractor, 5092217A

Childrens Intake Form (age 5-10)

THANK YOU FOR TAKING THE TIME TO FILL IN THIS FORM

Patient Information

Childs Name	Parent/Guardians Name		
Postal Address	City	State	Postal Code
Home Phone	Mobile Phone		
Email	Childs Birthdate / /	Age	
Who is your Primary Care Physician			
Any other health Care Specialists?			
List Any Drugs/medications/vitamins your child is taking:			

Current Health Conditions

What Health Conditions bring your child to see us?

When did the condition begin? How did it start? ☐ Suddenly ☐ Gradually ☐ Post Injury

Has your child received care for this condition before? ☐ Yes ☐ No

If yes please explain

Is this condition ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

Health Goals For Your Child

What are your top three health goals for your child?

1. ______________________
2. ______________________
3. ______________________

What would you like to gain from Chiropractic Care

☐ **Resolve Existing Condition**

☐ **Overall Wellness**

☐ **Both**

Pregnancy and Fertility History

Tell Us About Your Pregnancy

Any Fertility Issues ☐ Yes ☐ No If Yes, Please Explain ______________________

Did Mother Smoke/ Drink ☐ Yes ☐ No If Yes, how many per week ______________________

Did Mother Exercise ☐ Yes ☐ No If Yes, explain ______________________

Was Mother Ill ☐ Yes ☐ No If Yes, explain ______________________

Any Ultrasounds ☐ Yes ☐ No If Yes, how many ______________________

Please Explain any notable episodes of mental or physical stress during your pregnancy

Please Explain any other concerns or notable remarks about your child's conception or pregnancy

Growth and Development History

Is/was your child ☐ Breastfed ☐ Formula Fed If Yes, type of formula? Difficulty with Breastfeeding? ☐ Yes ☐No

Did/Does your child ever suffer from colic, reflux, or constipation ☐ Yes ☐ No
if yes, explain

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head or have other repetitive behaviours ☐Yes ☐ No
If Yes, Please explain

Has your child missed or had delayed developmental milestones? ☐ Yes ☐ No
If yes please explain

Is your child clumsy (trips, falls, runs into thing regularly) ☐ Yes ☐ No

List Any Food Intolerance or Allergies, and when they began

Is your child a fussy eater? ☐ Yes ☐ No

How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ Pretty Average ☐ High amount of processed food

Please List Any Major Injuries, Accidents, Falls and/ or Fractures your child has sustained in his or her lifetime

Please list your child's hospitalization and surgical history, including year

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on schedule ☐ Yes, on delayed schedule
Any Vaccine reactions?

Has your child received any antibiotics ☐ Yes ☐ No
If yes, how many times and the reason

Night terrors or difficulty sleeping ☐ Yes ☐ No
If Yes Please explain

Behavioral, social or emotional issues ☐ Yes ☐ No
If yes explain

How many hours per day does your child typically spend watching a TV, tablet, computer or phone?

Is your Child involved in any sports or other hobbies/ activities, please list

Consent for Examination – New England Chiropractic

I consent to have the chiropractor perform a physical examination of my child.

Parent/ Guardian's Signature ______________________________ Date __________

*Patient Name*______________________________ *ID NUMBER*____________