Dr Janine Kinahan, Chiropractor, 2740344F
Dr Kathy Johansson, Chiropractor, 4611863J
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Pediatric Intake Form

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	Sex ☐ M ☐ F
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

Labour & Delivery History

Childs Birth was ☐ Natural Vaginal ☐ Scheduled C-Section ☐ Emergency C- Section At How Many Weeks was your child Born

Childs Birth was ☐ At Home ☐ At Birthing Center ☐ At Hospital Dr/ Obstetricians Name

Please Check Any Interventions/ Complications

☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other

Please Describe any concerns about labour/ delivery

Childs Birth Weight APGAR Score at Birth APGAR Score after 5 minutes

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 as an infant ☐ Yes ☐ No

if yes, explain

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head ☐ Yes ☐ No

If Yes, Please explain

At what age did the child Respond to sound_____ Follow and object_____ Hold their head up____ Vocalize____ Sit Up_____ Crawl_____ Walk_____ Eat Solids _____

List Any Food Intolerance or Allergies, and when they began

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?

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

Consent for Examination

I Consent to the examination of my child by the chiropractor.

Parent/ Guardian's Signature_____ Date _____

*Patient Name*_____ *ID NUMBER*_____