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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? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Post Injury
Has your child received care for this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes please explain	
Is this condition <input type="checkbox"/> Getting worse <input type="checkbox"/> Improving <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Unsure	

Health Goals For Your Child	
What are your top three health goals for your child?	What would you like to gain from Chiropractic Care
1. _____	<input type="checkbox"/> Resolve Existing Condition
2. _____	<input type="checkbox"/> Overall Wellness
3. _____	<input type="checkbox"/> Both

Pregnancy and Fertility History	
Tell Us About Your Pregnancy	
Any Fertility Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Explain _____
Did Mother Smoke/ Drink	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many per week _____
Did Mother Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain _____
Was Mother Ill	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain _____
Any Ultrasounds	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula Fed If Yes, type of formula?	Difficulty with Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did/Does your child ever suffer from colic, reflux, or constipation <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, explain	
Did/Does your child frequently arch their neck/back, feel stiff, or bang their head or have other repetitive behaviours <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please explain	
Has your child missed or had delayed developmental milestones? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain	
Is your child clumsy (trips, falls, runs into thing regularly) <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Any Food Intolerance or Allergies, and when they began	
Is your child a fussy eater? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How would you describe your child's diet? <input type="checkbox"/> Mostly whole, organic foods <input type="checkbox"/> Pretty Average <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, on schedule <input type="checkbox"/> Yes, on delayed schedule Any Vaccine reactions?	
Has your child received any antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times and the reason	
Night terrors or difficulty sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Please explain	
Behavioral, social or emotional issues <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____