Ultimate Family Chiropractic
Your Team Of Wellness Engineers
431 Huronia Road, Unit 6 - Barrie ON, L4N 9B3 | Phone: 705-735-1169 | Fax: 705-252-7833

Name: _____ Age: _____ Birth date: (M)_____ (D)_____ (Y)_____

Address: _____ City: _____

Grade in School: _____ # of Siblings: _____ and their ages: _____

Interests, Hobbies, Activities: _____

How did you learn about our clinic? (Patient? Promotion?) _____

Family Doctor's Name: _____ Phone Number: _____

The human body is designed to be healthy, however even the birth process, or regular childhood activities can cause stress and trauma to the spine. Please answer the following questions to help us create better health for your family.

Pregnancy History:

_____

Birth History:

☐ At Home ☐ At Hospital ☐ Premature
☐ Forceps ☐ Suction ☐ C-Section ☐ Resuscitation

Infant Feeding: **Immunization :**

☐ Breast ☐ Bottle ☐ Yes ☐ No

What are some other health concerns you have? (Diagnosis, Syndromes, Disease)

_____

Ever treated for an emergency? If yes, please explain:

_____

Congenital Abnormalities/Defects and/or Family Health Problems:

_____

Childhood Sports :

_____

Childhood injuries, falls, car accidents:

_____

Childhood surgeries:

_____

Has the patient seen a chiropractor in the past? Y / N If yes, when was their last adjustment? _____

What is the present health concern today? _____

How long has the infant/child had this condition? _____

What aggravates this condition? _____ What relieves it? _____

What other doctors have treated them for this condition? _____

HEALTH DANGERS DISCOVERY – "DISEASE CAUSATION ANALYSIS"

When completing this form, please account for pain and symptons whether current or in the past. Please check the appropriate boxes below.

- ☐ Rubella
- ☐ Chickenpox
- ☐ Mumps
- ☐ Measles
- ☐ Whooping Cough
- ☐ Other:_____

- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Pneumonia
- ☐ Chronic Cough
- ☐ Chronic Bronchitis
- ☐ Other:_____

- ☐ Allergies
- ☐ Bed Wetting
- ☐ Ear Infections
- ☐ Fainting
- ☐ Fatigue
- ☐ Other:_____

- ☐ Anemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema / Psoriasis
- ☐ Epilepsy
- ☐ Other:_____

- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Sacroiliac Pain
- ☐ Headaches
- ☐ Other:_____

- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Forgetfulness/Confusion
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Dizziness/Fainting

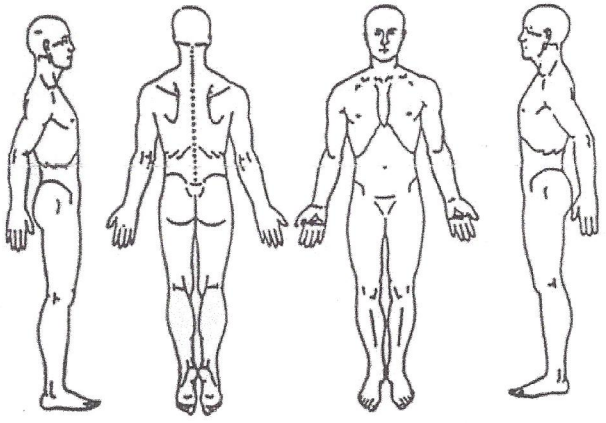
- ☐ Poor Appetite
- ☐ Heartburn/Indigestion
- ☐ Cramping
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Other:_____

- ☐ Frequent Sickness
- ☐ Growing Pains
- ☐ Hyperactivity / ADHD
- ☐ Loss of Sleep
- ☐ Ruptures / Hernias
- ☐ Difficulty Chewing / Jaw Trouble

- ☐ Painful Joints
- ☐ Painful Muscles
- ☐ Muscle Spasms
- ☐ Broken Bones
- ☐ Orthopaedic Problems
- ☐ Medications for above:_____

- ☐ Shoulder: R / L / Pain / Numbness / Tingling
- ☐ Arm: R / L / Pain / Numbness / Tingling
- ☐ Hand: R / L / Pain / Numbness / Tingling
- ☐ Hip: R / L / Pain / Numbness / Tingling
- ☐ Leg: R / L / Pain / Numbness / Tingling
- ☐ Knee: R / L / Pain / Numbness / Tingling
- ☐ Foot: R / L / Pain / Numbness / Tingling

Please mark an (x) on the diagram to show where the child feels pain.



Chiropractor/Exam CA Notes:

_____

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