West Lethbridge Family Chiropractic
Pediatric New Patient Form

Full Name of Child:_____ Alberta Health Care #:_____

Mother's Name:_____ Father's Name:_____

Address: _____ City:_____ Province: _____

Postal Code:_____ Home Phone:_____ Mom's Work Phone:_____ Dad's Work Phone:_____

How did you hear about our office? _____

If Parents are separated, do you have health care custodial rights for this child? (Please Initial)Yes_____ No____

Date of Birth (MM/DD/YYYY):_____ Age:_____ Male_____ Female_____ Number of Siblings: _____

Birth Weight_____ Birth Length_____ Current Weight _____ Current Length _____

Third Trimester Presentation: Vertex/"Normal": _____ Breech: _____Transverse:_____ Face/Brow: ____

Type of Birth: Normal Vaginal:_____ Forceps: _____ Cesarean: _____ Suction Cap/Vacuum:__

Location of Birth: _____

Problems during pregnancy (Please describe):_____

_____

Problems during labour and delivery (Please describe): _____

_____

Congenital Anomalies/ Defects? No_____ Yes _____ (If yes, please explain):_____

Infant Feeding: Breast_____Bottle _____ If bottle, which formula? _____

Number of hours sleeping per night: _____ Quality of Sleep: Good: _____Fair:_____Poor: _____

Family doctor: _____

Date of last visit:_____ Purpose of last visit: _____

Immunization History: _____

Number of doses of antibiotics your child has taken: During the last 6 months:_____ During his/her lifetime: ___

Has your child ever been to a chiropractor before? No ____Yes ___Date and Purpose of Visit: _____

_____

Has your child ever been treated on an emergency basis?_____If yes, please explain:_____

_____

If your child is here for a specific condition, please explain in the following spaces. If not, you may skip to next page.

Present problem: _____

Date this condition was first noticed: _____

Did something specific cause this condition? (Please describe) _____

Since the problem started, is it…. Improving _____ About the Same _____ Getting Worse _____

Does anything make it better? _____

Does anything make it worse? _____

Other health professionals seen for this problem (please list names and dates if applicable)

□ Chiropractor _____

□ Medical Doctor _____

□ Other_____ (PLEASE TURN PAGE OV

Has this child ever suffered from:

□ headaches	□ orthopedic problems	□ digestive disorders	□ behavioural problems
□ dizziness	□ neck problems	□ poor appetite	□ ADD/ADHD □ fainting
□ arm problems	□ stomach aches	□ hernia	□ seizures/convulsions
□ leg problems	□ reflux	□ muscle pain	□ heart trouble
□ joint problems	□ constipation	□ growing pains	□ chronic earaches
□ back pain	□ diarrhea	□ sinus trouble	□ anemia
□ poor posture	□ diabetes	□ asthma	□ Allergies to _____
□ colds/flu	□ trouble walking	□ scoliosis	□ Allergies to _____
□ colic	□ broken bones	□ bed wetting	□ Allergies to _____

Is there any other health condition your child is dealing with? _____

Please list any medications your child is currently taking: _____

Has this child ever sustained injuries in an auto accident? _____If yes, please explain _____

_____

Has this child ever suffered from a fall? _____If yes, please explain _____

Has your child ever had any surgery? _____

Is there anything else you would like to discuss about your child with Dr. Heilman? _____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine this child for further evaluation.

_____ _____

Signature of Parent or Guardian Date