



THE CHIROPRACTIC HOUSE & CO,
New Patient Paperwork- Child (5-13years)

Date _____

Personal Information

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: (_____) _____ Birth date: ____ / ____ / ____ (mm/dd/yy) Male Female Undisclosed
Parents Occupation: _____ Business / Employer: _____
Business Phone: (_____) _____ Extended Health Coverage: _____
Mother & Father Names _____ Siblings Names & Ages _____
Mobile Phone: (_____) _____ Name of Emergency Contact: _____
Emergency Contact's Relationship: _____ Phone Number For Emergency Contact: (_____) _____
Referred To This Office By: Yellow Pages Website RMT Patient/Dr. (name): _____
Email Address: _____

Please check the phrase that most represents your reason for care:

Wellness Prevention Feel good Symptom Relief

Current Complaint

*If this child has **no complaints** and this exam is for a spinal wellness check-up, please skip to * Past Medical history on next page*

Current complaint(s) _____

When did this condition begin? _____ Has this occurred before? No Yes

What aggravates the child's condition(s)? Sitting Standing Bending Lifting
 Walking Sleeping Other _____

What relieves the child's condition? Ice Heat Massage Stretches
 Bed Rest Walking Medication
 Other _____

Is this condition becoming Worse Better Constant Comes & Goes

Have you seen other doctors/therapists seen for this condition? No Yes Who? _____

How does this condition affect the Childs

Ability to sleep Ability to Eat. Behaviour. Ability to Play

*Past Medical History

Name of this child's Medical Doctor/Town _____

Date of last visit/examination _____

Does this child currently take any medications No Yes _____

Does this child currently take any natural supplements No Multivitamins Other _____

What is your personal satisfaction with this child's diet?

Highly Satisfied Satisfied Dissatisfied Highly Dissatisfied Why? _____

Please rate the quality of this child's sleep: Poor Fair Good # of sleeping hours at night: _____

Does this child suffer from any health conditions? No Yes _____

Did your child have any delays in meeting developmental milestones? For example; Holding up head, walking, crawling etc.
If so please list: _____

Has this child ever had any x-rays taken? No Yes Of what area(s)? _____

Past Injuries/ Trauma's

Any Major traumas/falls: _____

Birth Injuries: _____

Surgeries: _____

Current Fitness & Activity Level

poor moderate great Sports/Activities: _____

Family Health History

Is there a family history of any of the following conditions?

Scoliosis Allergies Heart Disease Arthritis Osteoporosis Cancer
 Diabetes Other _____

Please check if this child has had any of the following:

Musculoskeletal

- Low back pain
- Pain between shoulders
- Neck pain
- Headaches
- Arm pain
- Leg pain
- Jaw pain/clicking
- Growing Pains
- Scoliosis

Cardiovascular/Respiratory

- shortness of breath
- irregular heartbeat
- heart problems
- pneumonia
- bronchitis
- asthma

Gastro-Intestinal

- Poor appetite
- excessive thirst
- frequent nausea
- diarrhea
- constipation/gas
- bed wetting
- abdominal cramps
- heartburn
- Reflux

General

- fatigue
- high stress
- allergies
- poor sleep
- poor balance
- poor concentration
- recurring ear infections
- fainting

Informed Consent to Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined by Dr. Caitlin Lubberdink/Dr. Mitch Badz at the Chiropractic House & Co. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctor named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, intra-oral exam, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a "hands-on" approach so that we can best assess your child's health.

Office Policies Please Initial Below

_____ I agree to the DC's discussing with other health practitioners at the Chiropractic House & Co. health concerns related to my chief complaint.

_____ I agree to DC's releasing proof of attendance and payment information to 3rd party benefit and insurance companies.

Child Name

Parent Name

Parent Signature

Date

Witness Name

Witness Signature

Date