# MAPLES CHIROPRACTIC

## PEDIATRIC HISTORY FORM

**PATIENT DEMOGRAPHICS**

How did you hear about the clinic?

Today's Date: _____

☐Referral: _____

☐Internet ☐Radio ☐Live in the area

Child's Name_____

Birth Date: Day _____ Month _____Year _____ Age: _____ ☐ Male ☐ Female

☐ Same address & phone number as Parent(s)/Guardian(s) if not fill in below:

Address _____ Postal Code _____

City _____ Province _____ Phone Number (Home) _____

Mothers Name: _____ Mother's Mobile _____DOB ___ / ___ / ___

Fathers name: _____ Father's Mobile _____DOB ___ / ___ / ___

Pediatrician/Family MD _____City/Province _____

Last Visit: ____/____/____ Reason for visit:_____

**Purpose of this visit:** ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Pregnancy:

Were there any complications to the pregnancy?_____

Was mom on any medicine? (over the counter or prescription)?_____

Did mom or dad smoke during pregnancy? ☐ Yes ☐ No Who?_____

How many Ultrasounds were performed?_____

Birth and Delivery:

Where was the baby born? ☐ Hospital ☐ Home ☐ Birth Centre

How was your child delivered? ☐ Vaginal ☐ Forceps/Vacuum Extraction ☐ C-Section

How long was the labor? _____. How long was the delivery? _____

Epidural? ☐ Yes ☐ No

Infancy:

Was the infant vaccinated? ☐ Yes ☐ No

Was there any prolonged use of medicine or inhalers? ☐ Yes ☐ No

Did the infant suffer any traumas (serious falls or car accidents)? ☐ Yes ☐ No

Has the infant been under regular chiropractic care? ☐ Yes ☐ No

Breastfed? ☐ Yes ☐ No How long? _____

Childhood Years:

Did the child have any childhood illnesses? ☐ Yes ☐ No _____

Has the child had any surgeries? ☐ Yes ☐ No _____

How many rounds of antibiotics has your child taken in the last year? _____

Does the child play any sports? ☐ Yes ☐ No _____

Has the child been involved in any serious traumas? (car accidents, falls, etc.)_____

**OFFICE USE ONLY**

**ID:**_____

**Type of Patient:**

- ☐ **Whoelse Patient**
- ☐ **MPI Patient**
- ☐ **WCB Patient**
- ☐ **Massage**
- ☐ **Old New Patient (Walk-in / Reactivated)**

**Last Visit:**_____

- ☐ **Regular New Patient**

**Insurance Coverage:**_____

- ☐ **Signed INS Forms**
- ☐ **Signed Credit Form**

- ☐ **Free Consultation**
- ☐ **Dr. Gil**
- ☐ **Dr. Tracy**
- ☐ **Dr. Daniel**
- ☐ **Dr. Steven**
- ☐ **Dr. Nicole**
- ☐ **Dr. Glenn**

**Notes:**

## HAS YOUR CHILD EVER SUFFERED FROM:

- □ Headaches
- □ Leg Problems
- □ Reflux
- □ Muscle Pain
- □ Heart Trouble
- □ Joint Problems
- □ Constipation
- □ Growing Pains
- □ Chronic Earaches
- □ Backaches
- □ Diarrhea
- □ Ruptures/Hernia
- □ Seizures/Convulsions
- □ Orthopedic Problems
- □ Digestive Disorders
- □ Behavioral Problems
- □ Dizziness
- □ Neck Problems
- □ Poor Appetite
- □ ADD/ADHD
- □ Fainting
- □ Arm Problems
- □ Stomach Aches
- □ Broken Bones
- □ Sinus Trouble
- □ Poor Posture
- □ Hypertension
- □ Asthma
- □ Scoliosis
- □ Anemia
- □ Colds/Flu
- □ Walking Trouble
- □ Colic
- □ Bed Wetting
- □ Sleeping Problems

## MAJOR HEALTH CONCERNS

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

**Problem 1.**_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____How did the problem(s) begin_____

Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other: _____

Have you ever had the problem before? _____

What makes the pain better? _____

What makes the pain worse? _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb ☐ Other: _____

Is there anything the doctor needs to know about this condition? _____

**Problem 2.**_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____How did the problem(s) begin? _____

Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____

Have you ever had the problem before? _____

What makes the pain better? _____

What makes the pain worse? _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb ☐ Other: _____

Is there anything the doctor needs to know about this condition? _____

***MARK 'X'** anywhere you feel pain: