Mommy&Me
Family Chiropractic

Today's Date:_____

Child's Name : _____ Referred by: _____
Parent/Guardian(s) Full Name:_____
Home Address: _____
Postal code: _____ City:_____ Province: _____
Phone:(H)_____(C)_____ (W)_____
Weight:_____ Height:_____ Sex:_____ DOB:_____
E-mail Address: _____
Manitoba Health Registration No. _____ PHIN # : _____

Chiropractic History

Have you previously seen a chiropractor? ☐Y ☐N If yes, with whom? _____
If Yes, when was your last visit and how long was treatment?_____
Have you ever had x-rays taken: ☐Y ☐N If yes, when and where? _____

Current Health Condition

☐ *Here for wellness and have no complaints (Please skip this section)*
Reason for today's visit: _____
Problem started: _____Why do you think it started? _____
How has the problem been progressing: ☐ Getting worse ☐ Better ☐ Staying the same
Does anything make it better? ☐Y ☐N _____
Does anything make it worse? ☐Y ☐N _____
Is it worse during certain times of the day? ☐Y ☐ N _____
Have you seen anyone else for this complaint? ☐Y ☐N If yes, with whom? _____
What were the results? _____
What was the treatment? _____
Are you currently using any home remedies? _____

Check any of the following conditions your child has suffered from :
□ Ear Infections □ Seizures □ Chronic Colds □ Headaches □ Asthma / Allergies □ ADHD / ADD
□ Digestive Problems □ Recurring Fever □ Growing / Back Pains □ Colic □ Bed Wetting □ Temper Tantrums □ Scoliosis □ Difficulty Sleeping □ Other _____

Medical History

Pediatrician: _____ Date of Last Visit: _____

Reason:_____

Vaccination History:☐Up to date ☐Scheduled Spread out ☐ Currently Unvaccinated

Antibiotics or other prescription history:_____

Family medical conditions/history: _____

Has your child suffered from any childhood disease: ☐Y ☐ N If yes, please fill out.

Chicken Pox: Age: ____ N/A Measles Age: ____ N/A Mumps: Age: ____ N/A Rubella: Age: ____ N/A

Whooping Cough: Age: ___ N/A Rubeola: Age: ____ N/A Other: _____ Age:____

Accident/Trauma/Injury History

Involved in Sports: ☐ Y ☐ N What type: _____

Any injuries from sports: ☐ Y ☐ N What type: _____

Car accidents: ☐ Y ☐ N How many: _____ Approximate dates: _____

Other Traumas/Accidents/Injuries: ☐ Y ☐ N What kind:_____

_____

Surgeries: ☐ Y ☐ N What type? _____ When?_____

Hospitalizations: ☐ Y ☐ N Reason?_____ When?_____

Emergency visits: ☐ Y ☐ N Reason?_____ When?_____

Is there anything else you would like to add to this health form? ☐ Y ☐ N

_____

_____

_____

Signature:_____ **Date:_____**