MEADOWOOD FAMILY CHIROPRACTIC

Personal Information

Today's Date:____/____/____(day/month/year)

CHILD INFORMATION

Last Name: _____First name: _____ (On Manitoba Health Card)

Name he/she prefers to go by: _____ M ___ F ___ Date of Birth:____/____/____(day/month/year)

Mother's full name: _____ Father's full name: _____ __

Name and Ages of other children in Family: _____

Address: _____City: _____ Province: ____ Postal Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parents email addresses: _____

MB Health Number (6 digits): _____ PHIN (9 digits):_____

Who can we thank for referring you to our office?_____

Have your child received chiropractic care before? Y N How long ago? _____

Were you pleased with her/his care? Y N

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The human body is designed to express health and function normally. However, events may occur in life, which can ***interfere*** *with this natural ability. This interference is most commonly caused by* ***vertebral subluxations,*** *resulting from* ***physical, chemical or emotional stress.***

Chiropractic *aims to locate and correct/reduce the vertebral subluxation and nerve interferences.*

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Reason for Today's Visit

What is the primary reason and/or health concern for your visit today? _____

When did this concern begin?_____ Has it occurred before? Y N Is it getting worse? Y N

What makes it worse? _____ What makes it better?_____

How is this concern mainly AFFECTING your child's QUALITY OF LIFE?_____

Have you sought help from other health practitioners for your above health concern? Y N

If yes, please, explain: _____

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Please check the boxes that most closely describes your current goals for your child health/well-being:

☐ *I am mainly concerned about relief of a particular symptom*

☐ *I am mainly concerned about relief of a symptom and preventing its return*

☐ *I want optimum health and well-being on every level available to me*

General Health

Does your child suffer from: (Please circle)

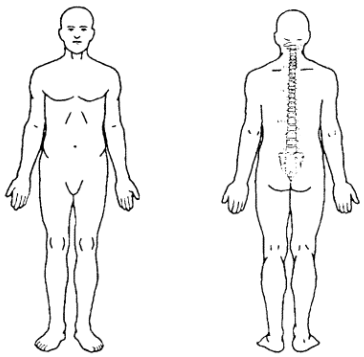
Headaches	Migraines	Dizziness	Fainting	Loss of Balance	
Buzzing in Ear	Ear infection	Allergies	Sinus problems	Fever	Freq Colds/Flu
Stomach upset	Constipation	Diarrhea	Diabetes		
Fatigue	Sleep problems	Depression	Irritability	High/Anxiety	
Asthma	Shortness of Breath		Other: _____		
Feet/Hands cold	Pins/Needles/Numbness: Arms or Fingers, Legs or Toes				

Does your child feel pain? (Please circle)

Neck Mid back Lower back Chest

Shoulder / Elbow / Wrist / Hand Hip / Knee / Ankle / Foot

Please mark any area of pain on the figures below



Does your child take any medication? Y N

Which one(s)?_____ ____For how long? _____

Has your child:

had surgery? Y N When? _____

Please explain: _____

been involved in a car accident or any other major fall or trauma? Y N

When? _____ Please explain:_____

Would you say your child eat a balanced diet including: Y N

- plenty of: vegetables fruits proteins healthy fats water

- low in: sugar white products (flour, rice,…) processed and fried foods

What kind of exercises/sports is your child involved in? _____

How many times a week? _____ On average, how many hours of sleep every night? _____

What vitamins/supplements is he/she taking? _____

How many hours each day does your child spend watching tv, or using electronic devices? _____

Family History of: (Please circle)

Father's side:	Heart Disease	Cancer	Arthritis	Diabetes	Other_____
Mother's side:	Heart Disease	Cancer	Arthritis	Diabetes	Other_____