Child Intake Form

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Name of child:_____ Date:_____

Age:_____ Date of Birth:_____ (M/D/Y) Sex (Circle): M F

Address:_____
Street City Postal Code

E-mail Address:_____

Home Telephone Number: _____ Cell phone number: _____

May we leave messages relating to your child's visits? Y / N Which Phone Number? _____

Emergency Contact Name and Relation: _____

Emergency Contact Phone Number: _____

How did you hear about me? (Please check one of the following)

- ☐ Absolute Wellness Centre staff (who?): _____
- ☐ Absolute Wellness Centre patient
- ☐ Friend
- ☐ Family member
- ☐ www.absolutechiropracticwindsor.ca
- ☐ Facebook
- ☐ Newsletter
- ☐ Other: _____

Referred by:
_____

Other Health Care providers your child is currently seeing (MD/Specialist/ND/Chiropractor, etc., name, address, phone number):

1. _____
   _____
   ( ) _____
2. _____
   _____
   ( ) _____
3. _____
   _____
   ( ) _____

Child's health concerns in order of importance:

Complaint	Since	Possible Causes

For girls:
Date of first menses:_____

Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, surgeries, injuries and any hospitalizations, along with approximate dates:

Condition/Illness/Surgery/Injury/Hospitalization	Date

What medications is your child currently taking? (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Medication/Supplement	Since	Dose

Does your child have any allergies (medicines, environmental, etc.)? Yes No
If yes, please specify: _____

How many times (approximately) has your child been treated with antibiotics? _____

Does your child frequently use any of the following? (circle)

Aspirin / Tylenol / Other pain killers / Laxatives / Antacids / Diet pills / Birth control

Caffeine—form and amount/day:_____

Please list past prescription medications and indicate time of usage:
_____
_____
_____

Please indicate what immunizations your child has had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster: when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ Flu vaccine: When? _____
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Guardacil (HPV vaccine): when?_____

Other:_____
Please indicate if any caused adverse reactions: _____

Does your child get regular screening tests done by another doctor? (Blood tests, etc.) Y / N
How long has it been since your child has been to a medical doctor? _____
Which of the following conditions are a current or recurring problem in your child's life?

- ☐ Loss of consciousness
- ☐ Numbness/tingling
- ☐ Fever/chills
- ☐ Difficulty swallowing
- ☐ Hay fever/Allergies
- ☐ Rashes/eczema/dry skin
- ☐ Acne
- ☐ Cold sores
- ☐ Diabetes
- ☐ Fainting
- ☐ Seizures/convulsions
- ☐ Dizziness
- ☐ Frequent colds/flus
- ☐ Loss of weight
- ☐ Fatigue/weakness
- ☐ Headaches
- ☐ Head injury
- ☐ Vision problems
- ☐ TMJ concerns
- ☐ Earaches
- ☐ Ear infections
- ☐ Decreased hearing
- ☐ Easy bruising
- ☐ Boils/hives
- ☐ Change in mole
- ☐ Night sweats
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma/bronchitis
- ☐ Strep throat
- ☐ Sinusitis/sinus problems
- ☐ Sunstroke
- ☐ Tonsillitis
- ☐ Bleeding disorders
- ☐ Anemia
- ☐ Chest pain
- ☐ Murmurs
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Heart problems
- ☐ Poor digestion
- ☐ Trouble swallowing
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Belching or gas
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Muscle spasms/cramps

- ☐ Weakness/loss of muscle strength
- ☐ Shoulder, elbow or wrist pain
- ☐ Hip, knee or ankle pain
- ☐ Warts
- ☐ Worms
- ☐ Pain on urination
- ☐ Blood in the urine
- ☐ Bedwetting
- ☐ Urgency, frequency, or hesitancy of urination
- ☐ Anxiety
- ☐ Depression
- ☐ Anorexia
- ☐ Bulimia

Has your child lost any weight recently? How many lbs/kg? _____

Diet

Does your child have any food allergies or intolerances? Please list.

_____
_____
_____

Does your child have any dietary restrictions? (religious, vegetarian/vegan, etc.)

_____
_____
_____

Describe a **typical day's diet**:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (type and quantity): _____

Family History

Indicate if a close relative (parent, sibling, grandparent) has had any of the following:

- ☐ I don't know my family medical history

Condition	Please indicate which family member
Allergies	
Arthritis	
Asthma	
Heart disease	
High Blood pressure	
Cancer	
Diabetes	
Depression	
Drug Abuse/Alcoholism	
Kidney Disease	
Other Mental Illness (Please Specify)	
Other Autoimmune diseases (Please specify: Lupus, Inflammatory Bowel Disease, etc.)	
Other	

Environment

Hobbies: _____

Does your child exercise regularly? Y / N What do they do for exercise? How much? How often?

_____
_____
_____
_____

How many people live in your home? Please specify. (spouse, children, grandparents, etc.)

_____
_____

Is your child exposed to significant tobacco smoke (home, daycare, etc.)? Y / N
Is your child frequently exposed to animals (pets at home or daycare, etc.)? Y / N

How many hours does your child sleep each night? Does he/she sleep well?_____

_____

Is your child regularly exposed to toxins or other hazards (home, school, hobbies, etc.)? Please describe.

_____
_____

Does your child have a strong emotional support system? (family, friends, mentors, etc.) Y / N

How would you describe the emotional climate of your home?

_____
_____
_____

Does your child enjoy school? How is he/she doing in school?

_____
_____
_____
_____

Is there anything else you feel is important that has not been covered?

_____
_____
_____