UXBRIDGE CHIROPRACTIC CENTRE

Kendra Clifford, N.D.
905-852-7704
26 Brock St. E., Uxbridge, ON L9P 1P1

Child Intake

Child's Name _____ Date of Birth _____

Who is filling out this form? Name _____ Relationship _____

How did you hear about our clinic? _____

Emergency Contacts

1. Name _____ Phone (H) _____

Address_____ (W)_____

_____

Relationship to child _____

2. Name _____ Phone (H) _____

Address_____ (W)_____

_____

Relationship to child _____

Whom does the child live with? _____

Other Health Care Providers

1._____ 2. _____ 3. _____

_____ _____ _____

Phone#_____ Phone # _____ Phone # _____

What are your child's health concerns, in order of importance:

1. _____

2. _____

3. _____

4. _____

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Child's Medical History

Please indicate any serious conditions, illness or injuries, and any hospitalizations with approximate dates:

_____

_____

_____

Which of the following diseases has your child had?

☐ Rubella (German Measles)	☐ Roseola	☐ Impetigo
☐ Measles	☐ Scarlet Fever	☐ Mononucleosis
☐ Chicken Pox	☐ Strep Throat	☐ Ear Infections
☐ Whooping Cough	☐ Mumps	

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all CURRENT medications and supplements (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

Please list all PAST prescription medications

_____

_____

How many times has your child been treated with ANTIBIOTICS? _____

Which of the following immunizations has your child had?

☐DPP (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza	☐ Hepatitis B
☐ Tetanus Booster when? _____	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Chicken Pox
☐ Other _____		

Please indicate if any of the above has caused an adverse reaction:

_____

_____

Has your child had any screening test (i.e. blood, hearing, vision)? ☐ Yes ☐ No
If Yes, please list:

_____

_____

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Child's Diet

How was your infant fed?

☐Breast –fed: how long? _____ ☐ Formula ☐ Milk ☐ Soy

☐Other _____

Were foods introduced before 6 months? ☐ Yes ☐ No

If yes please list:

_____

What foods were introduced between 6-12 months?

_____

_____

Did your child ever experience colic? ☐Yes ☐No

Was it? ☐ Mild ☐Moderate ☐Severe

Does your child have any food allergies or interolerances? ☐Yes ☐No

If yes please list:

_____

_____

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

☐Yes ☐ No If yes please list:

_____

_____

Describe a typical day's diet for your child

Breakfast_____ Snacks _____

Lunch_____ Beverages_____

Dinner _____

Health and Development

How was your child's health in the first year? ☐ Poor ☐Fair ☐Good ☐ Excellent ☐ Unknown

At what age did your child first?

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern

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_____

Describe your child's temperament

_____

Describe your child's behaviour and performance at school

_____

_____

Prenatal Health

What was the health of the parents at conception?

Mother: ☐ Poor ☐Fair ☐ Good ☐ Excellent ☐ Unknown
Father ☐ Poor ☐Fair ☐ Good ☐ Excellent ☐ Unknown

What was the health of the mother during the pregnancy?
☐ Poor ☐Fair ☐ Good ☐ Excellent ☐ Unknown

How was the mother's diet during pregnancy?
☐ Poor ☐Fair ☐ Good ☐ Excellent ☐ Unknown

What was the mother's age at the time of this child's birth? _____

Did the mother receive prenatal medical care? ☐ Yes ☐ No ☐Unknown

Did the mother experience any of the following during the pregnancy?
☐Bleeding ☐High blood pressure ☐Nausea ☐Vomiting
☐Diabetes ☐Thyroid problems ☐Physical Trauma
☐ Emotional Trauma ☐ Other _____

Did the mother use any of the following substances during the pregnancy?
☐Recreational drugs: Type? _____
☐ Prescription Medications: List? _____
☐ Over – the – counter Medications: List? _____
☐ Supplements: List? _____
☐ Tobacco ☐Alcohol ☐Other: _____

Birth History

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Term Length ☐Full ☐Premature _____ wks ☐ Late _____ wks

Length of labour _____ Child's weight at birth: _____

Was the birth: ☐ Vaginal ☐C-Section ☐Induced ☐Forceps ☐ Anaesthesia

Were there any complications? ☐Yes ☐No
If Yes Explain
_____
_____

Did the child experience any of the following at or shortly after the birth?
☐ Jaundice ☐Rashes ☐Seizures
☐Birth Injuries_____ ☐Birth Defects_____
☐Other_____

Family History

Do you know the family history ☐Yes ☐No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Who & Relationship	Symptoms	Who & Relationship
Allergies		Birth Defects	
Asthma		Juvenile arthritis	
Diabetes		Other	
Kidney Disease			

Do either of the parents have a chronic illness? ☐ Yes ☐No
If yes please describe
_____
_____

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Child's Environment

Is the child in? ☐School ☐Daycare ☐Home Care ☐Other

What are the child's favourite activities?

_____

_____

Does the child exercise regularly? ☐Yes ☐No

How much? _____

How often? _____

How much television does your child watch? _____ hours/day

How often does your child read, or is your child read to (not for school)?
☐Daily ☐Several times/week ☐Weekly ☐Less than Weekly ☐Never

Does anyone in the child's household smoke? ☐Yes ☐No

Are there any animals in the home? ☐Yes ☐No
What kind?

_____

How is the child's home heated? _____

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)? Please describe:

_____

_____

How would you describe the emotional climate of the child's home?

_____

_____