



Updegrove Chiropractic Clinic

General Information

Patient Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Telephone _____ Parent's Business Telephone _____

Date of Birth (D/M/Y) _____ Sex _____ Age _____ Weight _____ Height _____

Parent/Guardian Names _____

Emergency Contact _____ Telephone _____

Provincial Health Card Number _____

Purpose for contacting us? _____

Other doctors seen for this condition? Y N List Names and treatments _____

Other health problems? _____

Were you referred to us? By Whom? _____

Your Child's Health Profile

General History

	Yes	No	?		Yes	No	?
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Auto accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family Health History _____

Previous Chiropractor _____ Date of last visit _____ Reason _____

Were you satisfied? _____ Why? _____

Name of pediatrician _____ Date of last visit _____ Reason _____

Number of doses of antibiotics your child has taken:

a.) In the last six months: _____

b.) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

a.) In the last six months: _____

b.) Total during his/her life: _____

Vaccination History: _____

Detailed History

Feeding History

Yes No ? Details & Comments

Breast fed? How long? _____

Formula? How long? _____

Introduced to solids at how many months? _____

Introduced to cow's milk at how many months? _____

Prenatal History

Complications during pregnancy? Describe: _____

Ultrasounds during pregnancy? How many: _____

Medications during pregnancy/delivery? Please list: _____

Cigarette/alcohol use during pregnancy? _____

Location of birth Hospital Home Other

Birth interventions Forceps Vacuum extraction C-Section

Delivery complications? Describe _____

Birth stats Weight Length APGAR scores

Childhood diseases

Yes No ?

Chicken Pox

Age: _____

Rubella

Age: _____

Rubeola

Age: _____

Mumps

Age: _____

Whooping Cough

Age: _____

Other diseases

Traumas

Yes No ?

Car accidents?

Describe: _____

High falls?

Describe: _____

Surgery?

Detail: _____

At what age was your child able to:

Respond to sounds

Cross crawl

Respond to visual stimuli?

Stand alone

Hold head up

Walk alone

Sit up

I hereby authorise Updegrove Chiropractic to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature _____ Relationship to patient _____

Date _____

Condition Details & History
(for children able to answer the following questions)

Reason for consulting our office: _____

What are your expectations?: _____

How do you want us to address your problem/condition?

Temporary Relief

Maximum correction

How long have you had this condition? _____

Have you had similar problems in the past? _____

What activities aggravate your condition? _____

Does anything relieve your condition? _____

Is it worse in the morning or the night? _____

Is it constant? _____

How long does it generally last? _____

Does the pain radiate? _____ To what parts of the body? _____

Other Doctors seen for this condition: MD DC DO DDS

Doctor's Name: _____ Diagnosis _____

Doctor's Name: _____ Diagnosis _____

X-Rays taken? ___Y___N___ Treatments? _____

Medications? _____ Physical Therapy? _____

Results: _____

Length of time under care: _____

Is the condition interfering with any of the following?:

School _____ Sleep _____ Daily Routine _____

Is it getting progressively worse? _____

How long since you've felt good? _____