Sellars Chiropractic
& Wellness Centre

69 Margaret Avenue North
Waterloo, Ontario, N2J 3P8
519-208-6900
info@sellarrwellness.com

# CHIROPRACTIC PEDIATRIC INTAKE FORM

## Pediatric (age 0 – 12)

**Patient Information**

Date: _____ Child's Name: _____

Parent 1 Name: _____ Parent 2 Name: _____

Address: _____ Postal Code: _____

Phone (H):_____ (C): _____ Work: _____ext._____

Email: _____

Child's Age: _____ Weight: _____ Height: _____

Birthdate: _____ Birth Place: _____

School/daycare: _____ Family MD/Pediatrician: _____

Referred by: _____

**Current Health Condition**

Purpose of appointment/current complaint: _____

When/how did the current complaint occur: _____

Is the complaint: New / Recurring

Did it come on: Suddenly / Gradually / Comes & Goes

Did a fall, injury or trauma contribute to the current complaint: _____

Is your child presently taking medication/or under any other medical care:_____

For what conditions: _____

**Past Health History (please fill out if child is under the age of 1)**

**Birth History:**

Length or pregnancy: Full term (weeks) _____ / Early (weeks) _____ / Late (weeks) _____

Any issues during pregnancy for mom/baby: (position of baby, blood pressure etc.)

_____

Type of delivery: Normal vaginal / Breech / Cesarean

Invasive procedures: Epidural / Forceps / Vacuum

Length of labour: _____ Normal / Difficult

Birth weight: _____ Birth Length: _____ Congenital anomalies: _____

**Infant History (please fill out if child is under the age of 1)**

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Feeding: Breast / Bottle / Formula Latching Well: Yes / No Breast Preference: Y / N / right / left

Sleeping Quality: Good / Fair / Poor Average hours/night: _____ Average hours in a row: _____

Trouble falling asleep: Always / Occasional / Never

**General Health History**

Any known health conditions/allergies: _____

Illness/Injuries: _____

Hospitalizations/Suugeries/Stitches/Xrays:_____

Previous Massage / Craniosacral Treatment: _____

Vaccination history: _____

Last doctor's appointment: _____ Concerns: _____

Treatment for any health conditions in the past year: _____

**Lifestyle (please circle any that apply to your child):**

Activities: Basketball / Dance / Running / Skiing / Swimming / Hockey / Soccer

Other: _____

Computer / desk time: _____ hours/day

Diet: Good / Fair / Poor

Sleep Quality: Good / Fair / Poor

Please check any of the following conditions that are currently a problem; and underline any that were a problem in the past:

| **MUSCLE & JOINT** | **GENERAL** | INFANCY |
|---|---|---|
| Sore muscles | Fatigue | Colic |
| Sore joints | Allergies | Tilting head to one side |
| Growing pains | Difficulty sleeping | Difficulty nursing |
| Muscle cramps | Dizziness / fainting | Preferred side nursing |
| Muscle jerking | Earaches / infections | Slow weight gain |
| Back problems | Nose bleeds | Fussing in specific positions |
| Neck problems | Sore throat/ frequent colds / flu | Screaming / crying |
| Painful tailbone | Asthma | |
| Pain between shoulders | Chronic cough | ORGANS |
| Spinal curvature | Enlarged glands | Bedwetting |
| Arthritis | Loss of weight | Constipation / diarrhea |
| Difficulty chewing | Poor exercise / appetite | Anemia |
| Clicking in jaw | Nervousness | Thyroid issues |
| General stiffness | Depression / confusion | Vomiting |
| Walking problems | Vision / dental / hearing problems | Skin eruptions / eczema |
| Feet turn in / out | Hyperactivity | |
| Coordination problems | Behavioral problems | OTHER CONCERNS |
| Headaches | Epilepsy / seizures | |
| Pain in ankles / knees / hips | Rheumatic fever | _____ |
| | Stomach aches | |