BEDDINGTON CHIROPRACTIC AND MASSAGE

# Infant & Child Care Intake Form

Date: _____

Name _____
Age _____ Date of Birth _____
Gender: Male ☐ Female ☐
Alberta Health Care number _____

Primary Contact Information
Name _____
Relation to patient _____
Age _____ Date of Birth _____
Gender: Male ☐ Female ☐
Home Address _____
City _____ Province ____ Postal Code _____
Home phone (___) _____ E - mail address: _____
Business Phone (___) _____Cell Phone (___) _____
What is the best way to reach you? _____

Please describe why you have come to Beddington Chiropractic and Massage today:
_____
_____
_____

Name of Medical Doctor/Clinic: _____
Phone: _____
Date of last visit: _____ Health Concern: _____

Has your child experienced any of the following? Please indicate as;
**C**= *currently* experiencing
**P**= *previously* experienced

Asthma ☐
Sinus problem ☐
Strep throat ☐
Recurrent fevers ☐
Rashes ☐
Food sensitivities ☐
Frequent diarrhea ☐
Flatulence ☐
Neck Pain ☐
Trouble feeding on one side ☐

Respiratory tract infection ☐
Ear infection ☐
Frequent colds/ Croup ☐
Eczema ☐
Allergies ☐
Digestive problems ☐
Constipation ☐
Headache/ migraine ☐
Torticollis/ head tilt ☐
Back pain ☐

Growing pains ☐
Red, painful, swollen joints ☐
Frequent crying spells ☐
Slow or aberrant reflexes ☐
Bed wetting ☐
Tip toe walking ☐
Tremors/ shaking ☐
Autism ☐

Scoliosis ☐
Colic ☐
Failure to thrive/ slow weight gain ☐
Asymmetrical gait or crawling ☐
Sleep problems ☐
Seizures ☐
ADD/ ADHD ☐

Do you have a specific concern that brings you in today? _____
_____
_____
Does you baby appear to be in pain or discomfort? Y ☐ N ☐
If yes, how so: _____
Have you seen any other health care practitioner about this complaint? Y ☐ N ☐
If yes, who and when: _____
Has you child ever taken medication? Y ☐ N ☐
If yes, for what and when: _____
Has your child ever experienced this complaint before? Y ☐ N ☐
If yes, when and did they receive treatment for it: _____
_____
Has your child ever had x-rays? Y ☐ N ☐
If yes, when and why: _____

Birth History

Adopted/ Unknown ____
Birth weight _____ Birth Length _____
APGAR score if known (x/10): 1min _____ 5 min _____
Was you baby ever administered to Neonatal Intensive Care? Y ☐ N ☐
If yes, why and for how long: _____

Health History

How many hours does your baby sleep at night?_____
Childs preferred sleeping position?_____
Are you currently breast-feeding? Y ☐ N ☐
If yes: exclusively ☐ formula supplemented ☐
If no, did you previously? Y ☐ N ☐ If yes, for how long: _____
Does your child experience any feeding difficulties? Y ☐ N ☐
If yes, please describe: _____
Does you child have a one-sided breast-feeding preference? _____
Does you child spit up after feeding frequently? _____
Does you child pass a lot of intestinal gas? _____

Developmental History

Has your child ever fallen from a high place? N ☐ Y: _____
Has your child ever been involved in a motor vehicle accident? N☐ Y ☐
If yes, when and did they receive treatment: _____
Has your child ever broken any bones? N ☐ Y: _____
Has your child ever been seen on an emergency basis? Y ☐ N ☐
If yes, when and what for: _____
Has your child had any previous surgeries? Y☐N ☐
If yes, when and what for: _____