Country Hills Chiropractic & Wellness

PRE-TEEN CONSULTATION FORM (6-12 years)

Alberta Health Care # __/__/__/__/__/__ - __/__/__/__

Full Name _____ Birth Date _____ /____/ _____
dd / mm / yy

Mother's Name _____ Father's Name_____

Address_____Postal Code _____

Phone (res) (____) _____ Phone (cell) (____) _____ Phone (cell) (____)_____

Age _____ Height _____ Weight _____ Number of Siblings _____

Reason for child's visit _____

Previous surgery, illness or accidents _____

Name of family physician _____

Has child had previous chiropractic care? _____ Doctor's Name _____ Last Visit _____

Who referred you or how did you hear about our clinic? (circle one and please specify name)

Family Member Friend Physician Phone Book _____
name

Is this a Auto Accident case_____ Date of Accident _____

I realize that Alberta Health Care Insurance Commission will not pay the Doctor's fee schedule and that I am personally responsible for payment. I further understand that I am responsible to submit my own claim through my insurance company if I have personal coverage.

If this is an auto accident case I understand that I am responsible for all debts incurred at this clinic which are due and payable after each visit unless special arrangements have been made with my insurance company.

_____ _____
Signature of Parent or Guardian (signifying the above to be true) Date

LIFESTYLE QUESTIONS

The completion of this record allows for you and your child to have an information base that is as important to you as it is to your doctor: Please be as accurate as possible in your answers!

1. Child spends most of the day with: a) Mother b) Father c) Grandparents d) Public School e) Home School f) Private School

2. Which hand is your child's dominate hand: Right____ Left____

3. Did your child have prior (earlier) health problems they have outgrown or that have been corrected: NO____ YES____ if yes, please explain _____

4. What is your child's bedtime:_____Number of hours of sleep per night:_____

Quality of sleep: a) Good b) Fair c) Poor d) Restless

5. Has your family experienced strong emotional distress such as: a) Separation b) Divorce c) Loss of parent d) Loss of sibling e) Recent death of someone close f) Near fatal disease g) Strong emotional upset h) Other _____

6. Does your child awaken frequently with a complaint: YES____ NO____

7. Has your child recently awoken complaining of pain: YES____ NO____

8. How would you describe your child's health: a) Excellent b) Very good c) Average d) Poor e) Sickly

9. How is your child's schooling progressing: a) No concerns b) Doing well c) Average d) Poor

10. Has there been a recent change in your child's energy level: NO____ YES____ If yes, is it higher or lower_____

11. Does your child seem to be developing as you would expect regarding size, strength & coordination: YES____ NO____ If no, please explain_____

12. Are there any concerns with your child's diet: NO____ YES____ If yes, please explain_____

13. Are you concerned with any of the following regarding bowel and bladder functions: a) Regularity b) Stool consistency c) Pain with bowel movement d) Bed wetting

HEALTH HISTORY

14. Please circle any of the following if they are a concern:

Mouth breathing, Snoring, Tonsillitis, Adenoids, Recurrent ear infection Tubes in ears, Hoarseness, Recurrent throat infections, Difficulty breathing, Watery or swollen eyes, Sinus infection, Recurrent eye infection

15. Please circle any occurrence of childhood diseases or conditions:

Mumps, Measles, Chicken pox, German Measles, Baby Measles, Anemia, Thrush, Hernia, Undescended testicles, Appendicitis, Other_____

16. Does your child have or complain of frequent headaches: NO____ YES____

17. Does your child complain of pain or soreness in the legs, knees, ankles or feet: NO____ YES____

18. Does your child complain of pain or soreness in the arms, elbows, wrists or hands: NO____ YES____

19. Is your child currently taking any of the following medications: a) Antibiotics, for what_____
    b) Tylenol c) Aspirin d) Ibuprofen e) Other_____

20. Is your child following an immunization program: NO____ YES____

21. Has your child had any reaction to an immunization program: NO____ YES____ if yes, please explain_____

22. Has your child had any allergic reaction to any medications: NO____ YES____ if yes, which medications_____

23. Does your child have any problems with dry scaly skin or rashes: NO____ YES_____

24. Has your child been examined by an allergist: NO____ YES____

25. Is your child having allergy shots: NO____ YES____

26. Has your child ever been hospitalized: NO____ YES____ if yes, why?
    _____

27. Has your child ever had any broken bones: NO____ YES____ if yes, what_____

28. Has your child ever experienced a dislocation: NO____ YES____ if yes, what_____

29. Has your child ever been involved in a Motor Vehicle Accident: NO____ YES_____ if yes, when_____

30. Has your child ever experienced any major trauma: NO____ YES____if yes, please explain_____

31. Has your child ever had any trauma to the spine: NO____ YES____

32. Have you noticed any unusual shoe wear: NO____ YES____

33. Do you have any concerns regarding your child's walking pattern: NO____ YES____

a) Limp b) Toe walking c) Scoliosis d) Pain e) Foot positioning f) Other_____

34. Date of last visit to the G.P:_____ Name of Dr. _____
35. Date of last visit to the Pediatrician:_____ Name of Dr. _____
36. Date of last visit to the Dentist:_____ Name of Dr._____
37. Does your child frequently have a low-grade fever: NO____ YES____ if yes, how often_____
38. Is there a history of high recurrent fevers: NO____ YES____
39. Does your child presently have a fever: NO____ YES____
40. Have you noted a history if frequent, recurrent swollen lymph nodes: NO____ YES____
41. Does your child have a bloated or distended abdomen: NO____ YES____
42. Have you noted any changes or difficulty with speech: NO____ YES____
43. Are there any hereditary health problems: NO____ YES____ if yes, what_____
44. Is your child involved in a physical education program: NO____ YES____
45. Is your child having any visual problems: NO____ YES____
46. Have your child's eyes been checked by an optometrist: NO____ YES____
47. Do you have any concerns regarding your child's health that were not addressed in the previous questions: NO____ YES____ if yes, explain
    _____
    _____

Thank you for completing this form!