NAME: ____

ADDRESS: ____

TELEPHONE: ________________ WORK: ______________________________

BIRTHDAY: ________________ OHIP: ______________________________

REFERRRED BY: ____

CHIROPRACTIC PEDIATRIC EXAMINATION

BIRTH DELIVERY: a)Natural__ b)Spinal Anesthetic__ c)Induced__ d)Forceps__

MOTHER'S HEALTH DURING PREGNANCY: ______________________________

PREVIOUS ILLNESS/SURGERY: ______________________________

FALLS (stairs, slipping, etc.) DATE: ______________________________

WHEN DID THE CHILD START CRAWLING: ______________________________

WALKING: ______________________________

IS CHILD PHYSICALLY ACTIVE? YES_____ NO_____ SPORTS? ______________

DOES YOUR CHILD HAVE ANY OF THESE PROBLEMS?

poor sleeping habits___
nightmares___
stomach upsets___
poor appetite___
constipation___
diabetes___

diarrhea___
allergies___
leg pains___
knee pains___
headaches___
backaches___

breathing problems___
hyperactive___
frequent colds___
bedwetting___
increased thirst___
genetic defects___

HEREDITARY FACTORS

a) Scoliosis___
b) Diabetes___
c) Spinal problems___
d) Hypoglycemia___
e) Allergies___
f) Genetic defects___

PREVIOUS CHIROPRACTIC CARE: ______________________________

SIGNATURE OF PARENT OR GUARDIAN: ______________________________