circle chiropractic

Mission Statement
Our mission is to care for our community through empowerment and awareness of lifestyle choices to maximize health potential.

Philosophical Statement
True health solutions begin by eliminating the cause of disease, not just addressing symptoms.

PEDIATRIC INTAKE FORM

Patient Name: _____ PHN:_____
Address: _____ City:_____
Province:_____ Postal Code:_____ Phone Number:_____
Date of Birth: (d/m/y)_____ Age:_____ Gender: M F
Names of Parents/Legal Guardians: _____

HEALTH HISTORY

Purpose of this appointment: Spinal Check-up_____ Other:_____
Has this child had previous chiropractic care? Y N
Has this child seen another doctor for this condition? Y N
Doctor's name and prior treatments:_____
Other Health Concerns:_____
Pertinent Family History:_____
Number of Antibiotics doses your child has taken: In the past 6 months _____ In lifetime____
Other prescription medications: Previously_____ Currently_____
Allergies/Intolerances:_____
Number of bowel movements per day:_____ Hours of sleep per night:_____
Have you chosen to vaccinate your child? Y N
Reactions following vaccinations:_____

PRENATAL HISOTRY

Ultrasounds during pregnancy: Y N Number:_____
Complications during pregnancy: Y N
Describe:_____
Complications during delivery: Y N
Describe:_____
Medications during pregnancy or delivery: Y N
Describe:_____
Location of birth: Home_____ Birthing Centre_____ Hospital_____
Type of Delivery:_____ Vaginal _____ Forceps _____ Vacuum Extraction _____ C-Section
Cigarette/Alcohol use during pregnancy: Y N If yes, how much:_____
Genetic Disorders: Y N List:_____
Developmental disorders or challenges:_____
Breast-fed: Y N How long?_____ Formula-fed: Y N How long?_____

PAST HEALTH HISTORY

Automobile collisions: Y N Describe injuries:_____
Sports/recreational activities:_____
List any injuries (falls, broken bones, concussions, etc.,):_____
_____
Has your child ever been seen on an emergency basis: Y N
Reason:_____
Other traumas not listed above:_____
Hospitalization or surgery:_____
Check any of the following that apply to your child:
____ Asthma ____ Allergies ____Hyperactivity ____Bed-Wetting
____ Ear Infections ____ Skin Problems ____Difficulty Sleeping ____Colic
____Constipation/Diarrhea ____ Nutritional Deficiencies ____Insufficient physical activity

The above information is true and accurate to the best of my knowledge.
Print Child's Name:_____
Print Parent's or Legal Guardian's Name:_____
Parent or Guardian's Signature:_____
Date Signed:_____