Child and Adolescent Intake Form

Lakeshore Family Chiropractic
Box 1131 (2-40 Centre Street)
Gimli, MB R0C 1B0
Phone: 1 (204) 642-4842

Child's Name: ______________________________ **Mom:** ____________________________
Address: ____ **Dad:** ____________________________
Manitoba Health Number: ___________________________ Birth Date: (DY/MM/YY) ______________

Mainly for Moms:

1. **Tell us about your pregnancy:**
   Did you carry to full term? ____
   Describe any complications and when they occurred:
   ____

   ____

2. **Tell us about your delivery and birth of this child:**
   Did you use: ______ a midwife? _____ Hospital? _____ Obstetrician?
   Did you have a C-Section? ______ Were forceps used? _______
   Vacuum Extraction? ______ Were you induced? _______
   Did you have an Epidural? ______ Was it a difficult birth? _______
   What was the baby's APGAR Score? ______ At 5 minutes? _______

3. **Tell us more:**
   Did you breastfeed? _____ How long? _________ What formula after that? ___________________
   Did you consume alcohol during your pregnancy? _______ How much? ____________________________
   Did you smoke? _____ How much? _________ How long? _____________________________
   Any exposures to ultrasound? _____ How many? __________
   Did you take any medication during your pregnancy? _____
   For what? __________________________ What type? ____

   ____

4. **As a baby/toddler. (birth to 4 years), did any of the following occur?**
   __ Fall from a change table
   __ Tumble down stairs
   __ Fall out of crib
   __ Involved in car accident
   __ Fall off of playground equipment
   __ Play in "Jolly Jumper"
   __ Tonsilitus
   __ Reaction to vaccination
   __ Frequent crying spells
   __ Frequent fevers
   __ Frequent bouts of diarrhea
   __ Constipation
   __ Sleeping problems
   __ Frequent colds
   __ Did not gain weight
   __ Other _________________________________

   Please explain, if you checked any of the above: ____

   ____

5. **As a young child (5 – 12 years), did any of the following occur?**

   __ Fall from a tree
   __ Fall off of a bicycle
   __ Fall off of playground equipment
   __ Sports accident
   __ Car accident
   __ Stomach pains
   __ Scoliosis
   __ Bed wetting
   __ Hyperactivity/Autism
   __ Learning difficulties
   __ Asthma
   __ Allergies
   __ Leg/knee pains
   __ Other _________________________________

   Please explain, if you checked any of the above: ____

____

6. **Tell us about any vaccinations your child has had:** ____

____

7. **As a child or adolescent, has your child experienced any of the following:**

__	Headaches	__	Numbness in arms/hands	__	Foot/ankle/knee pains
__	Dizziness	__	Arm/wrist pains	__	Tingling in arms/legs
__	Ringing in ears	__	Sleeping problems	__	Neck/back pains
__	Asthma	__	Allergies	__	Shoulder pains
__	Hyperactivity	__	Stomach problems	__	Growing pains
__	Fatigue	__	Weight gain/loss	__	Other ___________________

Please explain, if you checked any of the above: ____

____

8. **Which of the problems you have checked off is the worst?** ______________________________________

____

Is this problem: Constant __ Intermittent __ Occasional __ Cyclic__

9. **How long has it persisted?** ____

10. **When it is at its worst, how does it make your child feel?** ______________________________________

____

11. **What have you done about it that has NOT worked?** ____

____

12. **What makes it worse?** ____

13. **What effect does this problem have on your child's body functions?** ______________________________

____

14. **Describe any hospital stays:** ____

____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** __________

____

16. **List any medications your child is currently taking**: ____

____

17. **To summarize, what is your purpose for this appointment?** ______________________________________

____

18. **Is there anything else you feel we should know?** ____

____

Signature of Parent or guardian: ________________________ **Date:** __________________________________