ELEVATION CHIROPRACTIC

ELEVATION CHIROPRACTIC – HEALTHCARE FOR THE ADVENTURER

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

How did you hear about the clinic?

Today's Date: _____ ☐Referral: _____

MB Health # (6 digit)_____

MB Health # (9 digit)_____ ☐Internet ☐Radio ☐Live in the area

Child's Name_____

Birth Date: Day _____ Month _____Year _____ Age: _____ ☐ Male ☐ Female

Phone Number (Home) _____Height:_____ Weight:_____ Shoe Size:_____

Address _____ Postal Code _____

City _____ Province _____

Mothers Name: _____ Mother's Mobile _____DOB ___ / ___ / ___

Fathers name: _____ Father's Mobile _____DOB ___ / ___ / ___

Pediatrician/Family MD _____City/Province _____

Last Visit: ____/____/____ Reason for visit:_____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

How was your child delivered? ☐ Vaginal ☐ Forceps/Vacuum Extraction ☐ C-Section

How many round of antibiotics has your child taken in the last year? _____

HAS YOUR CHILD EVER SUFFERED FROM:

□ Headaches	□ Seizures/Convulsions	□ Sinus Trouble	□ Fall in baby walker
□ Orthopedic Problems	□ Leg Problems	□ Poor Posture	□ Fall from bed or couch
□ Digestive Disorders	□ Reflux	□ Hypertension	□ Fall from crib
□ Behavioral Problems	□ Muscle Pain	□ Asthma	□ Fall off swing
□ Dizziness	□ Heart Trouble	□ Scoliosis	□ Fall off bicycle
□ Neck Problems	□ Joint Problems	□ Anemia	□ Fall from high chair
□ Poor Appetite	□ Constipation	□ Colds/Flu	□ Fall off slide
□ ADD/ADHD	□ Growing Pains	□ Walking Trouble	□ Fall down stairs
□ Fainting	□ Chronic Earaches	□ Bed Wetting	□ Fall from changing table
□ Arm Problems	□ Backaches	□ Colic	□ Fall off monkey bars
□ Stomach Aches	□ Diarrhea	□ Broken Bones	□ Fall off skateboard/skates
□ Ruptures/Hernia	□ Allergies to_____	□ Sleeping Problems	□ Other: _____

OFFICE USE ONLY

ID:_____

Type of Patient:

- ☐ **Whoelse Patient**
- ☐ **Metro Marketing Patient**
- ☐ **MPI Patient**
- ☐ **WCB Patient**
- ☐ **Massage**
- ☐ **Old New Patient**

Last Visit:_____

- ☐ **Regular New Patient**

Insurance Coverage:_____

- ☐ **Signed INS Forms**
- ☐ **Signed Credit Form**
- ☐ **Free Consultation**
- ☐ **Read Subluxation Pamphlet**
- ☐ **Dr. Ryan**

Notes:

MAJOR HEALTH CONCERNS

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Problem 1. _____ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 _____

When did the problem(s) begin? _____ How did the problem(s) begin? _____

Is it: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ other:_____

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____

What makes the pain better?

_____

What makes the pain worse?

_____

Describe the pain: -

_____

Is there anything the doctor needs to know about this condition?

_____

Problem 2. _____ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 _____

When did the problem(s) begin? _____ How did the problem(s) begin? _____

Is it: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ other:_____

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____ What makes the pain better?

_____

What makes the pain worse?

_____

Describe the pain: -

_____

Is there anything the doctor needs to know about this condition?

_____

***MARK 'X'** anywhere you feel pain: