131 Union Street East.
Suite #103
Waterloo, ON
N2J 1C4

The Natural Way HEALTH CLINIC where healing begins

(T) 519-772-2116
(F) 866-731-5603
www.thenaturalwayclinic.com

CHILD CHIROPRACTIC INTAKE FORM

(Child up to the age of 13)

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will help to provide me with a general overview of your child's health on a physical, mental, and emotional level, and assist me in preparing a treatment plan that will best meet their individual health needs and goals.

Full Name: _____ Date: _____
Date of Birth: _____ (m/d/y) Age: _____ Sex: Male /Female/:Other_____
Who is filling out this form? (Name & Relation): _____

Parent/Guardian's Contact Information:
Name: _____ Relationship: _____
Mailing Address: _____
City: _____ Postal Code: _____
Email: _____
Telephone: May we leave a message?
Home/Eve: (____) _____ YES / NO
Work/Day: (____) _____ YES / NO
Cell: (____) _____ YES / NO
What is the best way to contact you? HOME / WORK / CELL

□ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

Other parent/guardian authorized to make decisions regarding this minor child?
_____
With whom does this child live? _____
If custody is shared, please indicate the child's living arrangements_____

EMERGENCY CONTACT
Name: _____
Phone: _____
Relation: _____

How did you hear about The Natural Way Clinic/ Who may we thank?

☐ Google ☐ Facebook ☐ Instagram

☐ Educational Talk ☐ Newsletter ☐ Yellow Pages

☐ External Practitioner: ☐ Patient Referral: ☐ The Natural Way Staff: ☐ Other:

_____ _____ _____ _____

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PREVIOUS CHIROPRACTIC CARE

Has your child had chiropractic treatment before? YES / NO
If **yes**, was it a positive experience? YES / NO
Please explain: _____
Are you interested in wellness maintenance care? YES/ NO

PRENATAL AND BIRTH HISTORY

How would you describe the health of the parents at the time of conception?
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown

How would you describe the health of the mother during the pregnancy?
Excellent Good Fair Poor Unknown

At what age did the mother of this child give birth? _____
Was this her first pregnancy? YES / NO
Was there any difficulty conceiving this child? YES / NO
What, if any, interventions were used to increase the chance of conception? _____
Please describe any health problems, stress, or complications that occurred during the pregnancy:
_____
Length of pregnancy: _____ wks
Length of labour: _____ hrs
Type of birth: Vaginal or C-section
How initiated: Spontaneous or Induced
Location: Hospital or Home or Birthing Centre
Interventions (circle): forceps vacuum epidural episiotomy other
Were there any complications during or immediately after labour & delivery? If so, please describe:
_____

POSTNATAL HISTORY

Birth weight: _____ Birth length: _____
APGAR Scores: _____
Were there any health concerns at birth? If yes, please describe first few weeks after birth, did your child experience any of the following?

□ Congenital birth defect
□ Fever
□ Infection
□ Jaundice
□ Skin conditions
□ Colic
□ vomiting
□ Restlessness
□ feeding difficulties
□ Constipation
□ Other _____

Age when child could first:
_____ Respond to sound
_____ Hold head up
_____ Follow object with eyes
_____ Sit alone
_____ Crawl
_____ Stand
_____ Walk alone

Any developmental delays or concerns? _____

PAST MEDICAL AND HEALTH HISTORY

Current Height _____ Current Weight _____
Any concerns about height or weight? _____
Please list any past serious injuries or illnesses, including when they occurred and any complications that your child may have experienced: _____

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Please list any hospitalizations or operations that your child has had, including why, when they occurred and any complications: _____
Has your child had any of the following illnesses?

- □ Chicken Pox
- □ Measles
- □ Mumps
- □ Rubella
- □ Whooping Cough
- □ Scarlet Fever
- □ Rosella
- □ Polio
- □ Meningitis
- □ Mononucleosis
- □ Tuberculosis
- □ Strep throat
- □ Frequent Ear Infections
- □ Rheumatic Fever

Please indicate which of the following vaccinations your child has received:

- □ DPT
- □ MMR
- □ Polio
- □ Haemophilus Influenza B
- □ Flu Shot
- □ Hepatitis A
- □ Hepatitis B
- □ Chicken Pox (Varivax)
- □ Tetanus booster
- □ Meningitis
- □ Other _____

Has your child ever had an adverse reaction to a vaccine? If so, please indicate which vaccine and the nature of the adverse reaction: _____
When was your child's last medical check-up? _____

FAMILY HEALTH HISTORY

Please indicate if any family members (parents, siblings, grandparents), have had or have the following conditions:

- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Stroke
- □ Cancer
- □ Seizures
- □ Kidney Disease
- □ Thyroid Dysfunction
- □ Asthma
- □ Allergies
- □ Arthritis
- □ Autoimmune disease
- □ Osteoporosis
- □ Depression
- □ Schizophrenia
- □ Alcohol/Drug abuse
- □ Other Mental Illness
- □ Other

Please circle (o) any condition/symptom currently causing you problems. Please <u>underline</u> conditions/symptoms that were a problem in the past:

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness
Pain
Tingling
Nervousness
Weight loss
Eating disorder
Anemia

EMOTIONAL
Depression
Anxiety
Mood swings/irritability
Phobia
Alcohol/Drug Abuse

MALE REPRODUCTIVE
Testicular mass
Prostate trouble
Hernia

FEMALE REPRODUCTIVE
Painful menstruation
Excessive flow
Hot flashes
Cramps/backache
Vaginal discharge/itching
Yeast infections
Ovarian cysts/PCOS
Endometriosis
Fibroids
Swollen breasts
Lumps in breasts
Nipple discharge

GASTROINTESTINAL
Bloating
Poor appetite
Indigestion
Heart burn/acid reflux
Excessive hunger
Belching or gas
Bad breath
Nausea
Vomiting blood
Abdominal pain/cramps over stomach
Constipation
Diarrhea
Hemorrhoids
Gall bladder trouble
Ulcer
Diabetes

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CARDIOVASCULAR
High cholesterol
High blood pressure
Low blood pressure
Bleeding disorder
Pain over heart
Stroke
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina
Palpitations

E.E.N.T
Blurred vision
Impaired vision
Double vision
Eye redness
Eye pain
Eye itching
Eye discharge
Eye dryness
Floaters
Deafness
Earache
Ringing/buzzing in ears
Ear discharge
Wax build-up
Frequent ear infections
Allergies
Sleep apnea
Post nasal drip
Loss of smell
Nasal polyps
Frequent colds
Frequent sore throats
Sinus infection
Enlarged glands/nodes
Enlarged thyroid
Speech problems
Difficulty swallowing
Cavities
Gum problems

MUSCLES & JOINTS
Stiff neck
Back ache
Swollen joints
Foot trouble
Shoulder pain
Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Arthritis
Weakness

RESPIRATORY
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

SKIN
Rashes
Itching
Dryness
Eczema
Psoriasis
Hives
Boils
Dryness
Lumps
Hair loss
Nail change

By signing this form, I certify that all of the information provided herein is complete and accurate to the best of my knowledge. If there are any changes to this information I will notify The Natural Way Health Clinic in a timely manner. I give permission to be contacted by The Natural Way Health Clinic as indicated in this form and for messages to be left at the indicated numbers. I give permission for an exchange of medical information to occur with those practitioners indicated within this form, including but not limited to, clinical notes, progress reports, referral for and results of additional diagnostic procedures. I am legally entitled to make health care decisions regarding this child and have the permission of any other parent and/or guardian from whom it is necessary to have permission.

Name of Patient or Parent/Guardian: _____
Signature: _____ **Date:** _____

Doctor: Dr. Michelle Cruickshank License #7101

Signature: _____ Date: _____