Wetaskiwin
Family Chiropractic
Complete Lifestyle & Alternative Healthcare

Welcome

ABOUT YOUR CHILD

Today's Date: _____ Name: _____
Date of Birth: mm/dd/yyyy _____ Age: _____ ☐ Male ☐ Female
Alberta Health Care Number: _____ Present Height: _____ Present Weight: _____
Alberta Blue Cross ID Number: _____ Group Number: _____
Mother's/Father's Name: _____
Address: _____ City: _____
Province: _____ Postal Code: _____ E-mail: _____
Phone: (H)_____ Bus/Cell: _____
Emergency Contact: _____ Phone: _____
How did you hear about our clinic? _____

REASON FOR VISIT

What is your main reason for contacting us? _____
When did this condition begin? _____
List other care undergone for this complaint, including medication: _____
Other health concerns: _____
Do you have a medical doctor? ☐ Yes ☐ No Physicians Name: _____
Is this injury in relation to a motor vehicle accident? ☐ Yes ☐ No
Have you previously received chiropractic care at another clinic? ☐ Yes ☐ No
If Yes, please provide: Location of Clinic _____
Name of Clinic _____

How did you hear about our clinic?
☐ Phonebook ☐ Passing By
☐ Relative ☐ Friend
☐ Other _____

Have You Ever?			**If Yes, please explain**
Had a broken bone?	☐ Yes	☐ No	_____
Had surgery?	☐ Yes	☐ No	_____
Had an major illness?	☐ Yes	☐ No	_____
Been hospitalized?	☐ Yes	☐ No	_____
Had strains or sprains?	☐ Yes	☐ No	_____
Used a cane, crutch or support?	☐ Yes	☐ No	_____

Are You Currently Taking Any?			**If Yes, please explain**
Prescription Medication?	☐ Yes	☐ No	_____
Over-the-counter medications?	☐ Yes	☐ No	_____
Vitamins/Minerals/Herbs?	☐ Yes	☐ No	_____

Describe your sleep: _____
Describe your weekly physical activity: _____

ADDITIONAL HEALTH INFORMATION

When did you last have?	NEVER	0-6 MOS	6-18 MOS	LONGER
X-rays	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐

Dietary Habits:	NONE	LIGHT	MODERATE	HEAVY
Fruits & Vegatables	☐	☐	☐	☐
Whole Grains/Fiber	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Other Sugar Products	☐	☐	☐	☐

Environmental Stressors:

Any vaccinations received? ☐ Yes ☐ No Specify: _____

Any illnesses requiring antibiotics? ☐ Yes ☐ No Explain: _____

Total number of courses of antibiotics to date: _____

Any pets at home? ☐ Yes ☐ No Specify: _____

Any smokers in the home? ☐ Yes ☐ No How much: _____

Sports played and what age did they begin: _____

Number of hours per week played: _____

Weight of school backpack: _____

Is your child under any stress? ☐ Yes ☐ No Explain: _____

_____

ROS - For Doctors Use Only

1. GENERAL: Weight changes, energy level, sleep pattern, growth patterns, fever, fatigue.

2. SKIN: Birthmarks, rashes, pallor, sweating, itching, bleeding, swelling, dryness, colour changes, lumps, changes in hair/nails
3. HEAD: Headaches, head injuries, dizziness

4. EYES: Vision disorder, pain, redness, excessive tearing, glasses

5. EARS: Hearing disorder, infections, dizziness, ringing in ears

6. NOSE & SINUSES: Frequent colds, nasal stuffiness, hay fever, nose bleeds, drainage, discharge, sinus troubles

7. MOUTH/THROAT: Dental/gum issues, sore throat, speech problems, hoarseness, sore enlarged tongue, last dental exam
8. LYMPHATICCS: Enlarged/painful lymph nodes