Hubbards Chiropractic
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Pediatric
Patient Intake Form

Child's Name _____ Today's Date _____
Parents/Guardians' Names _____
Address _____
City _____ Province _____ Postal Code _____
Home Phone (___) _____ May we leave a message? ❑ Yes ❑ No
Parent's Work Phone (___) _____ May we leave a message? ❑ Yes ❑ No
Parent's Cell Phone (___) _____ May we leave a message? ❑ Yes ❑ No
Email_____
May we add you to our email newsletter? ❑ Yes ❑ No (your information will not be shared)
How would you prefer to receive your appointment reminders? Text ❑ Email ❑ Phone Call ❑

Child's Date of Birth _____ Gender ❑ Male ❑ Female
Siblings Names and Ages _____

Previous Chiropractic Care? ❑ No ❑ Yes If yes, previous DC's name and last visit _____
_____
Family Doctor _____ Date of last visit and reason _____
_____

Please list other health care professionals from whom your child is currently seeking care
Name _____ Specialty _____
Name _____ Specialty _____
Name _____ Specialty _____

Do you have a specific concern that brings you in?
❑ No, I'm interested in a wellness check-up for my child
❑ Yes _____ If yes, does your child appear to be in pain or discomfort?
_____
When did this problem begin? _____ Is it ❑ Occasional ❑ Frequent ❑ Constant ❑ Intermittent
What makes it worse? _____
What makes it better? _____
Does it interfere with ❑ Sleeping ❑ Eating ❑ Daily Routine?
Is it worse at a certain time of day? ❑ No ❑ Yes - when? _____
Has your child had any other treatment for it? _____

Prenatal History

Any complications or trauma to the mother during pregnancy? ❑ No ❑ Yes – please describe
_____
Any ultrasounds? ❑ No ❑ Yes - how many and reason _____
_____

Any invasive procedures (i.e. Amniocentesis, CVS, etc)? ❑ No ❑ Yes - please explain

_____

Any exposure to alcohol, cigarettes, or second-hand smoke? ❑ No ❑ Yes _____
Any illnesses during pregnancy? ❑ No ❑ Yes _____
Any medications or drugs taken during pregnancy? ❑ No ❑ Yes _____

_____

Any supplements taken during pregnancy? _____

Birth History

Child's gestational age at birth _____ weeks _____ days
Birth weight _____ lbs _____ oz Birth length _____ inches/cm
Birth attendants ❑ Midwife ❑ Doula ❑ OB ❑ GP ❑ Other _____
Birth location ❑ Hospital ❑ Home ❑ Birthing Centre ❑ Other _____
Duration of labour and birth _____ hours Type of delivery ❑ vaginal ❑ C-section
Presentation of child ❑ cephalic (head-first) ❑ breech (feet-first)
Medications during labour/delivery? ❑ No ❑ Yes _____
Any methods of induction/augmentation used (i.e. Pitocin, gel, rupture of membranes)? ❑ No ❑ Yes

_____

Were any interventions used during delivery? ❑ Forceps ❑ Vacuum extraction ❑ Other _____
Any complications during delivery? ❑ No ❑ Yes – please explain _____
Any evidence of birth trauma to the infant? ❑ Bruising ❑ Oddly shaped head ❑ Stuck in birth canal
❑ Fast or excessively long birth ❑ Respiratory trouble ❑ Cord around neck

Growth and Development History

Was your child breast fed? ❑ No ❑ Yes – how long? _____
Was your child formula fed? ❑ No ❑ Yes – at what age was it introduced and what brand? _____

_____

Did/does your child have any of the following:

- Difficulty with latching/breastfeeding? ❑ No ❑ Yes _____
- Problems with bonding? ❑ No ❑ Yes _____
- Behavioural problems? ❑ No ❑ Yes _____
- Night terrors/sleep walking/trouble sleeping? ❑ No ❑ Yes _____

Do you have pets in your home? ❑ No ❑ Yes _____
Does your child attend day care? ❑ No ❑ Yes – at what age did they begin? _____
Average number of hours of "screen time" per week (TV, computer, video games, etc) _____
Do you feel that your child's social and emotional development is normal for his/her age? ❑ Yes ❑ No

_____

Physical/Chemical Stressors

Has your child ever had a serious fall? ❑ No ❑ Yes _____
Has your child ever been involved in a motor vehicle accident? ❑ No ❑ Yes _____
Has your child ever broken any bones? ❑ No ❑ Yes _____
Has your child ever been hospitalized? ❑ No ❑ Yes _____
Has your child ever been prescribed antibiotics? ❑ No ❑ Yes _____

Does your child take any medications? ❑ No ❑ Yes _____
Has your child been vaccinated? ❑ No ❑ Yes – at what ages? _____
_____
Any negative reactions to vaccines? ❑ No ❑ Yes _____
Does your child show any sensitivity to certain foods? ❑ No ❑ Yes _____

Please indicate whether your child has any of the following and if it is a current or past concern:

❑ Asthma
❑ Respiratory Tract Infections
❑ Sinus Problems
❑ Ear Infections
❑ Tonsillitis
❑ Strep Throat
❑ Frequent Colds/Croup
❑ Recurrent Fever
❑ Eczema
❑ Rashes
❑ Allergies
❑ Digestive Problems
❑ Frequent Diarrhea
❑ Constipation
❑ Flatulence
❑ Headaches
❑ Dizziness
❑ Fainting
❑ Fatigue
❑ Depression
❑ Neck Pain
❑ Torticollis/Head Tilt
❑ Back Pain
❑ Growing Pains
❑ Scoliosis
❑ Red, Swollen, Painful Joint
❑ Colic/Frequent Crying Spells
❑ Failure to Thrive/Slow Weight Gain
❑ Slow or Absent Reflexes
❑ Regression of Milestones
❑ Asymmetrical Crawling or Gait
❑ Tip-toe Walking
❑ Weight Challenges
❑ Bed Wetting
❑ Seizures
❑ Tremors/Shaking
❑ ADD/ADHD
❑ Autism

Comments
_____
_____
_____
_____
_____

Goals and Consent

What is your primary goal for your child at our clinic? _____

Parent(s) Name(s) _____
I/We hereby authorize and consent to the chiropractic evaluation of my child.
Parent/Guardian Signature _____ Date _____
Witness Signature _____