NETWORK*chiropractic.ca* | *Dr. Allison Barriscale* | *(905) 693-8804* | *allison@NETWORKchiropractic.ca*
450 Bronte Street South, #212 | *Milton, ON* | *L9T 8T2*

Welcome to **NETWORK***chiropractic.ca*

When you have completed this page please hand it into the reception desk.

Vital Information (Child)

Child's First Name _____Last Name _____

Address _____

City _____ Province _____ Postal Code_____

Home Phone_____ Business Phone _____ ext _____

Mobile Phone _____

Email address_____

Date of Birth: D ___ /M _____/Y _____

Name(s) of Parent(s) _____

Other children? ○ No ○ Yes - Names (ages): _____

Name of additional caretaker(s)_____

Emergency contact _____Phone _____

Has your family seen a chiropractor before? ○ No ○ Yes – If so, when? _____

Reason for seeking services at **NETWORK***chiropractic.ca*: _____

How did you find out about **NETWORK***chiropractic.ca*? _____

Is there anything about your child's nerve system and spine we should know about? _____

_____

What is your level of commitment to you and your child's life and well-being?

○ High ○ Medium ○ Low

Additional Comments: _____

_____

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Vital Information (Child, Continued…)

Thank you for completing this more detailed questionnaire. All the information we collect is confidential and is valuable in order for us to provide you with exceptional service. If you have any questions please ask the Chiropractor. Please inform the Chiropractor when you have completed this information.

First Name _____ Last Name _____

Name of previous chiropractor and date of last visit? _____
Describe Experience _____
Name of present MD/Pediatrician and address? _____
_____
Date and reason for last MD visit? _____
Does your child have any current health concerns? If yes, please describe and complete the following questions, if no move onto * _____
_____
When did this/these health concern(s) begin? _____
Have you sought advice or treatment from a health professional? ○ Yes ○ No
If yes, what were you told? _____
What was done? _____ Did it seem to work? ○ Yes ○ No
Please indicate how this condition affects your child's daily function and the function of your family? _____
_____
What concerns you about this situation? _____
_____
Why do you think your child is experiencing this health event? _____
_____
*What are your expectations of your chiropractic care at **NETWORK***chiropractic.ca*? _____
_____
To develop an understanding about Chiropractic, the body's healing ability, life force and the nervous system we request that you attend one of our special Wellness Lectures during your first month of your child's care. Are you interested in attending one of our seminars?
○Yes ○ No ○ Will consider

Family and Personal History:

Please list whether you or anyone in your close family has a history of any of the following:
Cancer _____
Diabetes _____
Heart disease/high blood pressure _____
High cholesterol _____
Any other health concerns _____

History of pregnancy, labour and birth:

Pregnancy
Name of Obstetrician/Midwife _____
Please list any medical or alternative, treatments or procedures done during pregnancy _____
_____
Please list any drugs, herbs or supplements taken during pregnancy _____
_____
Please list any traumas to the mother during pregnancy (e.g. accidents, emotional) _____
_____

Labour& Birth
Birth attendants (MD, Midwife, Doula) _____
Location of Birth_____
Mother's position during labour (back side, sitting standing, other) _____
_____
Was labour induced? ○ Yes ○ No
Did the mother receive any drugs before during or after the birth process? (Epidural, Morphine, Other) _____
Was an episiotomy performed? ○ Yes ○ No
Duration of labour_____
Duration of delivery (time spent in birth canal) _____
Birth Position? ○ Cephalic (head first) ○ Occiput Posterior (facing forward)
○ Breech (feet first) ○ Other _____
Any assistance required during birth? (e.g. forceps, vacuum extraction, manual assistance, Cesarean)_____
Any complications during or after birth? (e.g. stuck in birth canal, cord around neck)_____
_____
Any evidence of trauma during birth (e.g. bruises, marks) _____
Was your child subjected to any procedures following birth?
○ Silver Nitrate eye drops ○ Incubation (how long?) _____
○ Vitamin K injection ○ Separation from mother (how long?) _____
○ Respiration ○ Other_____
Was your child alert and responsive within 12 hours of delivery? Explain _____
_____
What was the child's gestational age at birth? _____weeks
Birth Weight _____Birth Length _____
Congenital Anomalies or defects present? _____

Growth and Development:

At what age did your child:
Follow an object _____ Respond to Sound _____
Hold up head_____ Sit unassisted _____
Vocalize _____ Talk _____
Teethe _____ Crawl _____
Walk _____ Run_____

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PHYSICAL STRESSORS, activities, habits, traumas or challenges:

Please list the details, treatments and age/date (as necessary) of past and present PHYSICAL experiences:
Surgeries/Hospitalizations _____
Falls (e.g. from couches, beds, change table) and accidents_____
_____
Traumas resulting in bruises, fractures or stitches _____
_____
Car Accidents (describe)_____
Other Past or Current Illness/Infection _____
How much (and what kind of) exercise does your child get?_____
_____
Is a school backpack used? ○ No ○ Yes (Heavy) ○ Yes (Light)
Other _____

CHEMICAL STRESSORS, activities, habits, traumas or challenges:

Please indicate present and past exposures during pregnancy to (per day/week):
Cigarette Smoke _____
Alcohol/Caffeine _____
Supplements: _____
Medications/procedures (e.g. amniocentesis, ultrasound) _____

Was your child breastfed? ○ No ○ Yes (until what age?)_____
Introduced to formula? ○ No ○ Yes (at what age?) _____
Introduced to cows milk? ○ No ○ Yes (at what age?) _____
Solid foods at what age? _____
Please list your child's history of antibiotic use and types _____
_____
Please list your child's history of vaccinations and the age given _____
_____
Reason for vaccinations? _____
Any adverse reactions? _____
Any smokers in the home? _____
Any pets in the home?_____

What are your child's typical daily food choices:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
What is your child's daily fluid intake? How many glasses of:
Water_____Juice _____Pop _____Dairy _____
Other_____

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EMOTIONAL/MENTAL STRESSORS activities, habits, traumas or challenges:

Any problems with lactation and/or feeding?_____
_____
Any problems with bonding with your child? _____
Any behavioural problems? _____
Any emotional traumas? (e.g. death in family, abuse, school)_____
Does your child sleep through the night? ○ Yes ○ No Sleeping Position?_____
How many hours does your child sleep a night? _____ Quality? _____
Any night terrors, sleep walking, bedwetting or difficulty sleeping?_____
_____
How many hours per week does your child watch television? _____
Approximate hours of playtime per week_____
Do you feel that your child's physical, social and emotional development is normal for their age?
(Please explain)_____