taylor creek CHIROPRACTIC

Confidential Health History Form

CHILD

Name:		**Cell Phone:**	
Address:		**Home Phone:**	
City:	**Prov:**	**Work Phone:**	
Postal Code:	**Gender: F / M / O**	**Birth Date:** D/M/Y	**Age:**
Email:		**School grade level:**	
Parent/Guardian:		**Relationship**	
Parent/ Guardian Phone:		**Email:**	

Health Insurance Company & coverage amount/year:

Name of Family Doctor:	**Date of last physical:**

List Exercises – Sports - Interests:

Would you like appointment reminders by: ☐ Email ☐ SMS (text)

List any allergies:

How did you hear about our office?

Have you had previous Chiropractic care? ☐ No ☐ Yes If yes, when was your last visit:

Indicate your primary symptom:

Is your symptom due to an accident or a fall? ☐ No ☐ Yes describe:

When did your symptom begin? **Have you had this symptom before?** ☐ No ☐ Yes

What do you think caused your symptom?

Have you had previous treatment for this symptom? ☐ No ☐ Yes, specify

Have you had X-ray, MRI or other tests for this symptom? ☐ No ☐ Yes, specify:

Does this symptom interfere with your: ☐ school work ☐ sleep ☐ mood ☐ activities ☐ family life

Rate the intensity of your symptom **1 2 3 4 5 6 7 8 9 10**

Least pain **Worse pain**

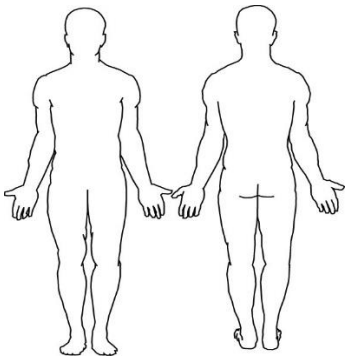
Is your symptom: ☐ **Constant** ☐ **Occasional** **Worse** ☐ **in the morning** ☐ **at night**

What aggravates your symptom?

What relieves your symptom?

Indicate on the diagram (to the right): **S** for **SHARP** Pain **D** for **DULL** pain

T - for **Tingling/ Numbness** **B** - for **Burning/ throbbing** **A** for **ACHING** pain



FRONT BACK

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CHILD

Please ☑ check the following boxes: "C" for the conditions you are CURRENTLY experiencing and under the "P" for conditions you have had in the PAST ** the *last row in italics are for females only* **

	C | P		C | P		C | P		C | P
Unexplained weight loss	☐|☐	Slurred speech	☐|☐	Poor appetite	☐|☐	Headaches	☐|☐
Unrelenting pain (day or night)	☐|☐	Previous stroke/ TIA	☐	Fever / chills/ sweats	☐|☐	Jaw pain	☐|☐
Loss of bowel/bladder function	☐|☐	Double vision	☐|☐	Frequent colds	☐|☐	Sinus pain	☐|☐
Loss of balance/ feel unstable	☐|☐	Heart palpitations	☐|☐	Ear infection	☐|☐	Neck pain	☐|☐
Poor concentration or memory	☐|☐	Fainting / dizziness	☐|☐	Heartburn/indigestion	☐|☐	Upper/Mid Back	☐|☐
Ear pain/ ringing	☐|☐	Chest pain	☐|☐	Constipation/Diarrhea	☐|☐	Shoulder pain	☐|☐
Spitting up phlegm/ blood	☐|☐	High blood pressure	☐|☐	Irritable bowel	☐|☐	Elbow pain	☐|☐
Difficulty swallowing	☐|☐	Low blood pressure	☐|☐	Nausea / vomiting	☐|☐	Wrist/hand pain	☐|☐
Cold hands or feet	☐|☐	Tremors	☐|☐	Asthma	☐|☐	Low Back pain	☐|☐
Swollen hands or feet	☐|☐	Difficulty breathing	☐|☐	Anxiety/ depression	☐|☐	Hip/Groin pain	☐|☐
Painful urination	☐|☐	Chronic cough	☐|☐	Difficulty sleeping	☐|☐	Knee pain	☐|☐
Blood in urine/ stool	☐|☐	Bronchitis	☐|☐	Pneumonia	☐|☐	Ankle/arch pain	☐|☐
Menstrual pain	☐|☐	*Irregular cycles*	☐|☐	Mood swings	☐|☐	Migraines	☐|☐

Indicate any other conditions of concern: _____

_____

Please check ☑ all stressors that apply

Prolonged sitting	☐	Poor sleep	☐	Prolonged standing	☐	Repetitive twisting	☐
Emotional stress	☐	Poor posture	☐	Repetitive lifting	☐	Prolonged screen time	☐
Fell /jumped from a height greater than 4 ft (e.g. play structure/ bunk bed)	☐	Had an impacts snowboarding/ skiing/ biking /trampoline etc.…	☐	Play contact sports	☐	Dropped as a baby/child	☐
History of concussion	☐	Fractured a bone	☐	Received stitches	☐	Had a surgery	☐
Had a sport's injury	☐	Sprained an ankle	☐	Had a serious fall	☐	Had emergency care	☐

Describe any major trauma or impact: _____

List any diagnosed condition(s): _____

List any medication you are currently taking: _____

List intake

Hours of sitting _____/day	Glasses of water: _____/day	Caffeinated drinks: _____/day	Food Intolerance/List:
Screen time:_____hrs/ day	Hours of sleep: _____/night	Hours of exercise: _____/week	

The fee for the New Patient Consultation and examination is 120$. X-ray digital imaging if required is 40$ - 80$.

Patient's Signature:_____

Parent/Legal Guardian's Signature: _____ **Date**: _____