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**

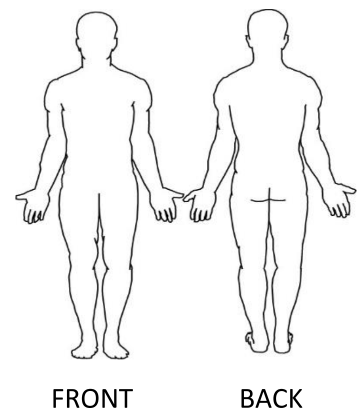
Is your symptom: ☐ **Constant** ☐ **Occasional** **Worse** ☐ **in the morning** ☐ **at night**

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



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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	☐|☐	Wrist/hand pain	☐|☐
Difficulty swallowing	☐|☐	Low blood pressure	☐|☐	Nausea / vomiting	☐|☐	Low Back pain	☐|☐
Cold hands or feet	☐|☐	Tremors	☐|☐	Asthma	☐|☐	Hip/Groin pain	☐|☐
Swollen hands or feet	☐|☐	Difficulty breathing	☐|☐	Anxiety/ depression	☐|☐	Knee pain	☐|☐
Painful urination	☐|☐	Chronic cough	☐|☐	Difficulty sleeping	☐|☐	Ankle/arch pain	☐|☐
Blood in urine/ stool	☐|☐	Bronchitis	☐|☐	Pneumonia	☐|☐	Migraines	☐|☐
Menstrual pain	☐|☐	*Irregular cycles*	☐|☐	*Mood swings*	☐|☐		☐|☐

Indicate any other conditions of concern: ______________________________

____

Please check ☑ all stressors you are currently

Prolonged sitting	☐	Poor sleep	☐	Prolonged standing	☐	Repetitive twisting	☐
Emotional stress	☐	Poor posture	☐	Repetitive lifting	☐		☐
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 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 110$. X-ray digital imaging if required is 40$ - 80$.

Patient's Signature:______________________________

Parent/Legal Guardian's Signature: ______________________________ **Date**: ____________________