M & Y Chiropractic Health and Wellness Centre
Dr. Darren Poncelet

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name______________________________________Date_________________________
Parent(s) Name____
Siblings Names(Ages)____
Address_____________________________________City_______________Prov.__________
Postal Code_________Home Phone(___)__________Bus Phone(___)_________________
Date of Birth________________Age_______Referred by__________________________________

Has your child ever received chiropractic care? ***Yes*** ***No***
If ***yes***, previous DC's name and last visit?____
Name of Medical Doctor____
Date of last MD visit and reason____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAMES______________________________WORK TEL.__________
I hereby authorize and consent to the chiropractic evaluation of my child.
PARENT/GUARDIAN SIGNATURE_______________________DATE__________
WITNESS SIGNATURE____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major____

Minor____

When did this problem begin?____

Is this problem (circle) ***occasional*** ***frequent*** ***constant*** ***intermittent***

Does problem radiate? ***Yes*** ***No*** If ***Yes***, where?____

What makes this worse? ____

What makes this better? ____

Is the problem worse during a certain time of the day? ***Yes*** ***No***
If ***Yes***, when? ____

Does this interfere with the child's sleep?____eating?____daily routine?____

Is this becoming worse? ____

Other professionals seen for this condition?_______________________________________

Results with that treatment?____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS:
(please tick if your child has had any of the following)

__headaches	__loss of taste	__weight gain	__upper back pain
__dizziness	__light sensitivity	__dental problems	__neck pain
__fainting	__face flushed	__fevers	__low back pain
__fatigue	__cold sweats	__heart palpitations	__radiating pain
__irritability	__bronchitis	__chest pressure	__stiffness
__depression	__pneumonia	__breast pain	__reduced mobility
__loss of balance	__difficulty breathing	__frequent colds	__numbness in leg(s)
__loss of concentration	__shortness of breath	__sinus congestion	__numbness in feet
__loss of memory	__asthma	__sore throats	__numbness in hand(s)
__ears buzzing	__urinary problems	__ear pain/infections	__weakness
__poor coordination	__constipation	__allergies	__muscle cramps
__vision changes	__diarrhea	__heartburn	__sleeping problems
__loss of smell	__weight loss	__bloating/gas	

__other:____

HISTORY OF BIRTH

What was the child's gestational age at birth?______weeks.

Birth weight _____lbs ____oz Birth length_______inches

Was your child's birth at home, in a birthing center or in a hospital? (circle one)

Was the birth considered medical or midwife? (circle one)

What was the duration of the labour and birth? _______hours

Was child born cephalic (head first) or breech (feet first)? (circle one)

Were there any complications? ***Yes*** ***No*** If ***Yes***, please explain____

____

Please circle any assistance which was used during birth

Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***

Was labour spontaneous or induced? (circle one)

Were medications or epidurals given to the mother during birth? ***Yes*** ***No***

If ***yes***, what was given? ____

APGAR score: at Birth______/10 After 5 minutes_____/10

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ***Yes*** ***No***

If ***no***, please explain____

At what age did the child:

Respond to sound_________	Follow an object__________
Hold up head ____________	Vocalize_________________
Sit alone________________	Teethe__________________
Crawl__________________	Walk____________________

Do you consider the child's sleeping pattern normal? ***Yes*** ***No***
If ***no***, explain____

FAMILY HEALTH HISTORY

Please note any health problems (ie. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mother's family____

Father's family____

Siblings____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. Falls, accidents, etc.) ***Yes*** ***No***
Please explain____

Any evidence of birth trauma to the infant? (please tick)

__Bruising
__Stuck in birth canal
__Respiratory depression
__Odd shaped head
__Fast or excessively long birth
__Cord around neck

Any falls from couches, beds, change tables, etc.? ***Yes*** ***No***
If ***yes***, please explain____

Any traumas resulting in bruises, cuts, stitches or fractures? ***Yes*** ***No***
If ***yes***, please explain____

Any hospitalization or surgeries? ***Yes*** ***No***
If ***yes***, please explain____
Any sports played? ____

Is a school backpack used? ***Yes*** ***No***
Is it heavy or light (circle one)

CHEMICAL STRESSORS

Was the child breast-fed? ***Yes*** ***No***
If yes, how long?____________________________
Formula introduced at what age? _______
Which formula?______________________________
Introduction of cow's milk at what age?________
Began solid foods at what age? _________
Type of foods?_______________________________
Food/Juice intolerance? ***Yes*** ***No***
Type?______________________________________

During pregnancy, did the mother: Smoke? ***Yes No*** How much?________________________________
Drink? ***Yes No*** How much?________________________________

Any illnesses during the pregnancy? ***Yes No*** ____

Any supplements taken during pregnancy? ***Yes No***____

Any drugs taken during pregnancy? ***Yes No*** ____

Any ultrasounds? ***Yes No*** How many and reasons for being done?____
____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ***Yes No***

Please explain____

Any pets at home? ***Yes No*** ____

Any smokers in the home? ***Yes No***

Vaccination History Vaccinations and age given?____
____

Any negative reactions? ***Yes No***____

Any antibiotics given? ***Yes No*** Reason____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ***Yes No*** ____

Any problems with bonding? ***Yes No*** ____

Any behavioral problems? ***Yes No*** ____

Any night terrors, sleep walking, difficulty sleeping? ***Yes No*** ____

Age of child when began daycare? __________

Average number of hours of television per week?_______

Do you feel that your child's social and emotional development is normal for their age? ***Yes No***
____

Thank you for completing this form. If there are any other questions which you have, you may write them in the space below.

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