ASCENT
INTEGRATIVE HEALTH

Pediatric (0-5) Chiropractic Patient Intake Form

To allow us to provide your child with the best possible care, please complete this form as thoroughly as possible. All information is strictly confidential. Contact Info: T: 403.262.1121 F: 403.262.1371 E: info@ascenthealth.ca

Patient Information

Date: _____ Gender: _____ Email (parent):_____

Child's Name: _____ Preferred Name: _____

Mother's Name: _____ Father's Name: _____

Street Address: _____ Postal Code: _____ City: _____ Prov: _____

Home Phone: _____ Cellphone: _____ Work: _____

Age: _____ Birthdate: (D) ____ / (M) _____ / (Y) _____ Weight: _____ Height: _____

Alberta Health Care Number: _____

**We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address?* □ Yes □ No

Medical Information

Family MD/Pediatrician's Name: _____ Clinic: _____

Date of last MD visit: _____ Reason: _____

What therapies has your child previously received? □ Chiropractic □ Massage □ Physiotherapy

**Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your child's medical doctor?* □ Yes □ No

Extended Health Benefits

Do you have a private insurance plan? ☐ No ☐Yes (Self) ☐Yes (Spouse)

Name of primary policy holder (Spouse/Parent): _____

We Dirtect Bill with the following companies, indicate if your policy is with one of the following:

☐Alberta Blue Cross ☐SunLife ☐Great West Life ☐ Johnson Inc ☐ Standard Life ☐ Chambers of Commerce

Policy No: _____ Member ID: _____ Group No: *(*ABC Only)* _____

Is this a Motor Vehicle Accident Case (MVA)? □ No □ Yes Date of the Accident: _____

How Did You Find Us?

□ Referred by Friend/Family □ Referred by Medical Doctor □ Internet/Website □ Street Sign

□ Referred by Trainer □ Walk In □ Health Care Event □ Other: _____

**Whom may we thank for this referral? _____

Current Health Condition

Primary Complaint/Purpose of Appointment: _____

When did this begin? _____

Has your child had this before? □ No □ Yes; when: _____ Is it getting: □ Worse □ Better □ Not Changing

Is the condition: □ Auto-Related □ Sports-Related □ Fall □ Other: _____

Has your child seen anyone else for this condition? □ No □ Yes: _____

Has your child had any imaging for this condition? □ X-Ray □ CT □ MRI □ Ultrasound Date: _____

Is your child presently taking any medications/supplements? _____

Are there any secondary complaints/conditions? _____

Birth History

Length of Pregnancy: □ Full Term (weeks): _____ □ Early (weeks): _____ □ Late (weeks): _____

Any issues during pregnancy for mom/baby? _____

Location of Delivery: □ Home □ Birthing Center □ Hospital

Type of Delivery/Interventions: □ Vaginal □ Cesarean □ Forceps □ Vacuum □ Breech □ Epidural

Length of Labor: _____ □ Normal □ Difficult APGAR Scores: _____ □ Jaundice

Birth Weight: _____ Birth Length: _____ Congenital Anomalies: _____

Infancy History

Feeding: □ Breast □ Bottle □ Formula Latching well: □ Yes □ No Breast Preference: □ No □ Left □ Right

Sleep Quality: □ Good □ Fair □ Poor Average Hours/Night: _____ Average Hours in a Row: _____

Trouble Falling Asleep: □ Always □ Occasional □ Never

General Health History

Any Known Health Conditions/Illnesses: □ No □ Yes; List: _____

Big Falls or Injuries: □ No □ Yes; List: _____

Hospitalizations/Surgeries: □ No □ Yes; List: _____

Fractures: □ No □ Yes; Where/When: _____

Any Allergies: □ No □ Yes; List: _____

Vaccination History: _____

Health Status Survey

Please check the box for any conditions or symptoms that your child has had in the ***past six months:***

Muscle & Joint
□ Sore Muscles
□ Sore Joints
□ Growing Pains
□ Muscle Cramps
□ Back Problems
□ Neck Problems
□ Pain b/w Shoulders
□ Spinal Curvature
□ Arthritis
□ Difficulty chewing
□ Walking Problems
□ Feet Turn In/Out
□ Coordination Problems
□ Headaches

General
□ Fatigue
□ Difficulty Sleeping
□ Dizziness
□ Fainting
□ Earaches/Infections
□ Sore Throat

General
□ Asthma
□ Chronic Cough
□ Enlarged Glands
□ Loss of Weight
□ Poor/Excessive Appetite
□ Nervousness
□ Depression/Confusion
□ Hyperactivity
□ Behavioral Problems
□ Frequent Colds/Flu
□ Epilepsy

General
□ Stomach Aches
□ Diarrhea
□ Eczema
□ Hernias
□ Rheumatic Fever
□ Colic
□ Night Terrors
□ Slow Weight Gain
□ Seizures
□ Bedwetting
□ Constipation