



The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxations. Vertebral Subluxations damages an optimally functioning spine and nervous system. This impairs your ability to have optimal health. Your experience with this office will not be only be of healing, but also of learning more about **Optimal Health and Healing**.

**PEDIATRIC PATIENT INFORMATION**

Print Full Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Alberta Health Care # \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Names of Parents/Guardian: \_\_\_\_\_ Ages of Siblings \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_ Best Way to Contact you \_\_\_\_\_

Emergency contact (name-Relationship) \_\_\_\_\_ (Where they could be reached) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Or were you referred by  Insurance Co.  Our Website  By our Location  Found us in the Phone book

Other, please explain \_\_\_\_\_

**REASON FOR SEEKING CHIROPRACTIC CARE**

Purpose For Contacting Us? \_\_\_\_\_

Other Doctors Seen for this Condition: YES / NO. Doctors' Names and Prior Treatments: \_\_\_\_\_

Other Health Problems? \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

Ear Infections       Asthma/Allergies       Colic       Scoliosis       Digestive Problems

Bed Wetting       Seizures       ADHD       Car Accident       Chronic Colds

Recurring Fevers       Headaches       Growing Pains       Temper tantrums / Mood altered

Difficulty Sleeping       Other \_\_\_\_\_

**Family History**

Previous Chiropractic Care YES/ NO Last Visit: \_\_\_\_\_ Name of Dr. \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Reason & treatment/prescriptions: \_\_\_\_\_

# of Prescriptions that your child has taken: During the past 6 mo \_\_\_\_\_ Total During his/her lifetime \_\_\_\_\_ List \_\_\_\_\_

Vaccination History: \_\_\_\_\_

## Pre Natal History

Name of Obstetrician or Midwife: \_\_\_\_\_

Location of Birth \_\_\_\_\_ Circle One: Hospital / Birthing Center / Home

How was the birth? \_\_\_\_\_ Any Complications? \_\_\_\_\_

Check all that apply \_\_\_ Vaginal \_\_\_ C-section \_\_\_ Emergency \_\_\_ Planned \_\_\_ Forceps used \_\_\_ Vacuum Extraction

Any Meds During Pregnancy / Delivery? YES/NO List \_\_\_\_\_ Birth Weight & Length \_\_\_\_\_

## Feeding History

Breast Fed YES/ NO , How Long \_\_\_\_\_ Formula Fed YES/ NO , How Long \_\_\_\_\_ Intro to Solids: \_\_\_\_\_ Months

Food / Juice Allergies Intolerances: YES/ NO , List \_\_\_\_\_

## Developmental History

During your child's development their spine is most vulnerable to stress and regular check ups by a Doctor of Chiropractic are for the prevention and early detection of stresses on their growing spine and nervous system. Did you notice any differences, difficulties or may have skipped some of the following stages:

\_\_\_ Response to Sound    \_\_\_ Hold Head Up    \_\_\_ Sit Up    \_\_\_ Rolling over    \_\_\_ Walking Alone

\_\_\_ Response to Visual    \_\_\_ Cross Crawl    \_\_\_ Stand Alone    \_\_\_ Cruising    \_\_\_ Feeding themselves

*According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc) Was this the case with your child? YES / NO*

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Lacrosse, Cheerleading, Martial Arts, Etc)? YES/ NO, List \_\_\_\_\_

Has your child ever been involved in a car accident? YES/ NO , List \_\_\_\_\_

Has your child ever been seen on a Emergency Basis YES/ NO , List \_\_\_\_\_

Prior Surgery: YES/ NO, List \_\_\_\_\_

## Childhood Diseases:

Chicken Pox Yes/No Age \_\_\_\_\_ Measles Yes/No Age \_\_\_\_\_ Mumps Yes/No Age \_\_\_\_\_ Rubella Yes/No Age \_\_\_\_\_

Whooping Cough Yes/No Age \_\_\_\_\_ Other Yes/No Age \_\_\_\_\_ Describe \_\_\_\_\_

## Authorization for Care of Minor:

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary, I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Parent/Guardian \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Thank you for choosing Dr. Marcy Kimpton of Motion Chiropractic**

**We look forward to helping you develop a healthier spine and nervous system and *express your life to the fullest.***

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