Lifestyle Health Centre

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Child Intake Form

Today's Date (mm/dd/yy):________/ ______/_______ Parent/Guardian Name: ___________________

Childs Name:____

Address: _____________________________________City: ____________Prov: ______Postal Code: ______________________

Phone #: Home: (______)____________________Work: (_____) _________________ Cell: (______)_________________

I prefer to be contacted at: ☐ Home ☐ Work ☐ Cell ☐ Email Sex: ☐ M ☐ F

Email:_________________________BC Care Card___________________

Birth Date (mm/dd/yy) _______/______/_________

EMERGENCY CONTACT Name: ________________________________

Relationship: ___________________ Home Phone: ___________________ Cell Phone: _________________

ACCIDENT INFORMATION

Is the condition due to an accident? □Yes □No If yes, please report to front desk for additional forms

To whom have you reported the accident? □ ICBC

How did you find our clinic? Check one:

☐ Friend/Family Name: _______________________________________ ☐ Internet ☐ Yellow Pages ☐ Clinic Signage

HEALTH PROFILE

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? ☐ Yes ☐ No

If yes, what was the doctor's name and when was your last visit? ____

How long were you receiving chiropractic adjustments? ____

Do you have an M.D. and when was the date of your last examination? ____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No Explain: ____

Who is your Dentist and when was the date of your last examination? ____

Have you ever had Physiotherapy? ☐ Yes ☐ No

If yes, who is/was your Physiotherapist and how long were you under care for? ______________________________________

Do we have your permission to send reports to any of the above Medical/Health Professionals? ☐ Yes ☐ No

HEALTH CONCERNS OR SYMPTOMS AND HOW THEY MAY AFFECT YOUR LIFE

Do you have any current symptoms or health concerns that brought you to our office? ☐ Yes ☐ No ☐ Wellness care/advice

If yes, please describe (the quality – achy, sharp, dull; duration – constant, occasional; pain – into legs or arms; anything that makes it better or worse) ______________________________

When did this situation or concern begin? ______________________________

Please grade the level to which this symptom or health concern affects these aspects of your functioning/quality

0 – It does not seem to affect me at all **2 – It seems to moderately affect me**
1 – It seems to slightly affect me **3 – It seems to drastically affect me**

Effect on walking ____ Effect on recreation/play ____ Effect on rest/sleep ____ Effect on exercise ____
Effect on social life ____ Effect on eating ____ Effect on sitting ____

Please grade the concern about this problem as it relates to your overall health (scale of 0-3) ____

Other stressors throughout our life impact our body's ability to adapt and function. Please take a moment to consider the impact of past or current stresses.

PHYSICAL STRESS

Have you experienced any of the following? If so please indicate if this happened in the past or is a current or ongoing concern **AND** also indicate the severity of the concern.

Birth Trauma ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________
Falls ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________
Vehicle Accidents ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________

Sports (either repetitive or specific incidents) ☐ Past ☐ Present / ☐Mild ☐ Significant

____

Please indicate if you consume any of the following using this scale:

D- Consume daily **W – Consume weekly** **M – Consume monthly** **N – Never consume**

Artificial Sweeteners _______ Soda Pop _______Dairy __________Refined Sugar ___________

EMOTIONAL STRESS

How would you grade your child's emotional/mental health? (Circle) **Excellent** **Good** **Fair**