Edina Family CHIROPRACTIC

Restoring Health Naturally

GENERAL INFORMATION

Patient Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Parent Email Address: _____

Home Phone: ( ) _____ Parent Business Phone: ( ) _____ Parent Cell Phone: ( ) _____

Birth Date: ____ / ____ / _____ Gender: M F Age: _____ Weight: _____ Height: _____

Parent/Guardian Names: _____

Emergency Contact: _____ Telephone: ( ) _____

Provincial Health Card Number: _____

Purpose for contacting us? _____

Other doctors seen for this condition? ❑ Yes ❑ No List names and treatments: _____

_____

Other health problems? _____

Were you referred to us? By whom? _____

YOUR CHILD'S HEALTH PROFILE

GENERAL HISTORY:

	YES	NO	?		YES	NO	?
Ear infections	❑	❑	❑	Auto accidents	❑	❑	❑
Asthma/Allergies	❑	❑	❑	Chronic colds	❑	❑	❑
Colic	❑	❑	❑	Recurring fevers	❑	❑	❑
Scoliosis	❑	❑	❑	Temper tantrums	❑	❑	❑
Digestive problems	❑	❑	❑	Headaches	❑	❑	❑
Bed wetting	❑	❑	❑	Other: _____			
Seizures	❑	❑	❑	_____			
ADHD	❑	❑	❑				

Family Health History: _____

Previous Chiropractor: _____ Date of last visit: _____ Reason: _____

Where you satisfied? _____ Why? _____

Name of pediatrician: _____ Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken:

a) In the last 6 months: _____

b) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

a) In the last 6 months: _____

b) Total during his/her life: _____

Vaccination History: _____

_____

DETAILED HISTORY

FEEDING HISTORY:
was your Child...

	YES	NO	?	DETAILS & COMMENTS
Breast fed?	❑	❑	❑	How long? _____
Formula fed?	❑	❑	❑	How long? _____
Introduced to solids?	❑	❑	❑	At how many months? _____
Introduced to cows milk?	❑	❑	❑	At how many months? _____

PRENATAL HISTORY:
did Mother have...

Complications during pregnancy?	❑	❑	❑	Describe: _____
Ultrasounds during pregnancy?	❑	❑	❑	How many: _____
Medications during pregnancy/delivery?	❑	❑	❑	Please list: _____
Cigarette/alcohol use during pregnancy?	❑	❑	❑	_____
Delivery complications?	❑	❑	❑	Describe: _____
Birth interventions?	❑	❑	❑	❑ Forceps ❑ Vacuum extraction ❑ C-Section
Location of birth:				❑ Hospital ❑ Home ❑ Other
Birth stats:				Weight _____ Length _____
				APGAR scores _____

CHILDHOOD DISEASES:

	YES	NO	?	DETAILS & COMMENTS
Chicken Pox	❑	❑	❑	Age: _____
Rubella	❑	❑	❑	Age: _____
Rubeola	❑	❑	❑	Age: _____
Mumps	❑	❑	❑	Age: _____
Whooping Cough	❑	❑	❑	Age: _____
Other diseases	❑	❑	❑	Describe: _____

TRAUMAS:

Car accidents?	❑	❑	❑	Describe: _____
High falls?	❑	❑	❑	Describe: _____
Surgery?	❑	❑	❑	Details: _____

At what age was your child able to:

Respond to sounds? _____

Respond to visual stimuli? _____

Hold head up? _____

Sit up? _____

Cross crawl? _____

Stand alone? _____

Walk alone? _____

AUTHORIZATION

I hereby authorize Edina Family Chiropractic to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature _____ Relationship to patient _____

Date _____

Dr. Christopher Bargmann
Edina Family Chiropractic

CONDITION DETAILS AND HISTORY

ANSWER THE FOLLOWING THE BEST YOU CAN.
WE REALIZE SOME OF THESE QUESTIONS MAY BE DIFFICULT TO ANSWER FOR SMALLER CHILDREN.

Reason for consulting our office: _____

What are your expectations: _____

How do you want us to address your problem/condition?

❑ Temporary relief ❑ Long-term correction

How long has your child had this condition? _____

Has your child had similar problems in the past? _____

What activities aggrevate your child's condition? _____

Does anything relieve your child's condition? _____

Is it worse in the morning or in the night? _____

Is it constant? _____

How long does it generally last? _____

Does the pain radiate? _____ To what parts of the body? _____

Other Doctors seen for this condition: MD DC DO DDS

Doctor's Name: _____ Diagnosis: _____

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Doctor's Name: _____ Diagnosis: _____

X-rays taken? ❑ Yes ❑ No Treatments: _____

Medications: _____ Physical Therapy: _____

Results: _____

Length of time under care: _____

Is the condition interfering with any of the following? ❑ School ❑ Sleep ❑ Daily Routine Describe: _____

_____

Is it getting progressively worse? _____

How long since your child has felt good? _____