Maple Meadows CHIROPRACTIC

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Kids Health History and Family Information

Patients Name: ______________________________ Today's date ____________
last first middle

Address ____
street city postal code

Gender M F Date of Birth (mm/dd/yyyy) ____________ Age ____________

Name of Parents / Guardians ______________________________

Home Phone ____________ Work number ____________ Cell Phone ____________

Text reminders: yes ☐ no ☐ Who is your provider? (telus, Bell, etc) ____________________

Email Address for reminders: ______________________ If you prefer not to receive our email newsletters, please check this box. ☐

****By checking a box above you are giving Maple Meadows Chiropractic permission to contact you for appointment reminders*

Medical Doctor ____

Do you need receipts for extended health insurance? ____________ ICBC? ____________

Who referred you to our office? ______________________________

Previous Chiropractic care? Y / N Whom? ______________________________

When? ______________________________

If there are any areas of concern please indicate them below

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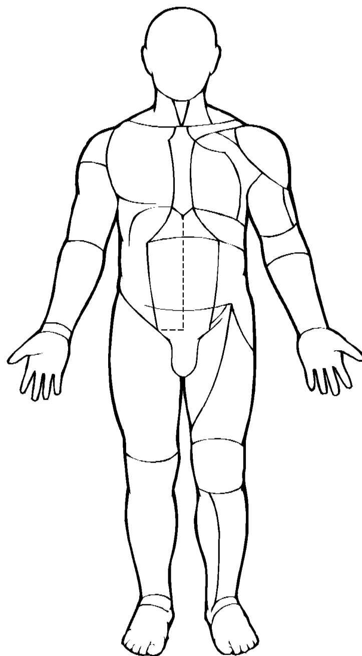

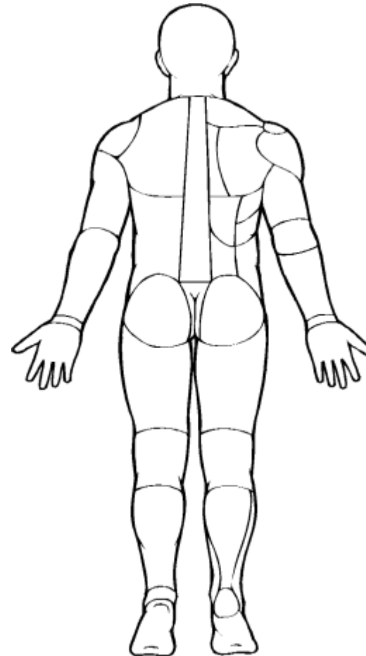

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Check any of the following conditions your child has suffered from over the past six months:

Scoliosis	Ear Infections	Seizures	Growing Pains	Asthma / Allergies
ADHD	Car Accident	Headaches	Recurring Fevers	Digestive Problems
Colic	Bed Wetting	Chronic Colds	Temper Tantrums	Other ______________

Family History ____

Number of doses of Antibiotics your child has taken ____

Other Medication your child has taken ____

Vaccination History ____

Prenatal History:

Complications during pregnancy? Y / N ____

Complications during delivery? Y / N ____

Birth weight/length ____

Genetic disorders or disabilities: ____

APGAR score if known ____

Feeding History:

Breast Fed? Y / N How long? ____

Formula? Y / N Type? ____

Food / Juice allergies? Y / N List: ____

Developmental History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. a bed, changing table, down stairs, etc.). Was this the case with your child?
Y / N When? ____

Is / has your child been involved in any high impact or contact type sports (ie. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y / N List: ____

Has your child ever been in a car accident? Y / N When? ____

Any other traumas or surgeries? Y / N List: ____

Childhood Diseases:

Chicken Pox	Y / N	Age ____________	Mumps	Y / N	Age ____________
Rubella	Y / N	Age ____________	Whooping Cough	Y / N	Age ____________
Rubeola	Y / N	Age ____________	Other	Y / N	Age ____________

Have we missed anything? ____

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