Dr. Brad Norman Dr. Paul Weber
NEW LIFE CHIROPRACTIC
320 Bayfield St. Barrie, ON L4M 3C1 735-1838

Date | Patient No.

PEDIATRIC PATIENT INTRODUCTION

Child's name: _____ Mother's name: _____

Address: _____ Father's name: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Mother's work phone: _____ Father's work phone: _____

Birthdate (mm/dd/yy): _____ Age: _____ Birth weight: _____ Current weight: _____

Sex: ☐ M ☐ F No. of siblings: _____ Birth length: _____ Current length: _____

Type of birth: ☐ Normal vaginal ☐ Forceps ☐ Breech ☐ Caesarean

Location of birth: ☐ Birthing centre ☐ Home ☐ Vacuum ☐ Hospital

Apgar score: _____ Was there presence at birth of: ☐ Jaundice (Yellow) ☐ Cyanosis (Blue)

Congenital Abnormalities/ Defects: _____

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

No. of hours sleep per night: _____ Quality of sleep: ☐ Good ☐ Fair ☐ Poor

Obstetrician/ Midwife: (name & location) _____

Paediatrician/ Family MD: (name & location) _____

Date of last visit to MD: _____ Purpose: _____

Immunization History: _____

Has your child ever been treated on an emergency basis? _____

Please describe: _____

HISTORY

Pregnancy History: _____

_____

Delivery/ Birth History: _____

_____

DEVELOPEMENTAL

At what age did your Child:

Respond to sound: _____ Follow an object with his/her eyes: _____
Hold head up: _____ Sit alone: _____ Crawl: _____
Stand: _____ Walk alone: _____

CHILDHOOD

☐ Chickenpox _____ ☐ Rubella _____
☐ Mumps _____ ☐ Rubeola _____
☐ Measles _____ ☐ Whooping cough _____
☐ Other: _____

Has this child ever suffered from:

- ☐ *Dizziness*
- ☐ *Diabetes*
- ☐ *Arthritis*
- ☐ *Neuritis*
- ☐ *Anemia*
- ☐ *Poor appetite*
- ☐ *Bedwetting*
- ☐ *Fainting*
- ☐ *Neck problems*
- ☐ *Joint problems*
- ☐ *Backaches*
- ☐ *Tuberculosis*
- ☐ *Headaches*
- ☐ *Digestive Disorders*
- ☐ *Rheumatic Fever*
- ☐ *Hyperactivity*
- ☐ *Convulsions*
- ☐ *Walking problems*
- ☐ *Arm problems*
- ☐ *Blood disorders*
- ☐ *Heart trouble*
- ☐ *Hypertension*
- ☐ *Asthma*
- ☐ *Sinus trouble*
- ☐ *Orthopedic problems*
- ☐ *Poor concentration*
- ☐ *Paralysis*
- ☐ *Broken bones*
- ☐ *Leg problems*
- ☐ *Stomach aches*
- ☐ *Recurrent earaches*
- ☐ *Cold/Flu*
- ☐ *Allergies*
- ☐ *Constipation*
- ☐ *Diarrhea*
- ☐ *Behavioural problems*
- ☐ *Muscle jerking*
- ☐ *Ruptures/ Hernias*
- ☐ *"Growing pains"*
- ☐ *Other* _____

_____

CURRENT HEALTH CONDITION

Current concern(s): _____

_____

Recent History: _____

_____

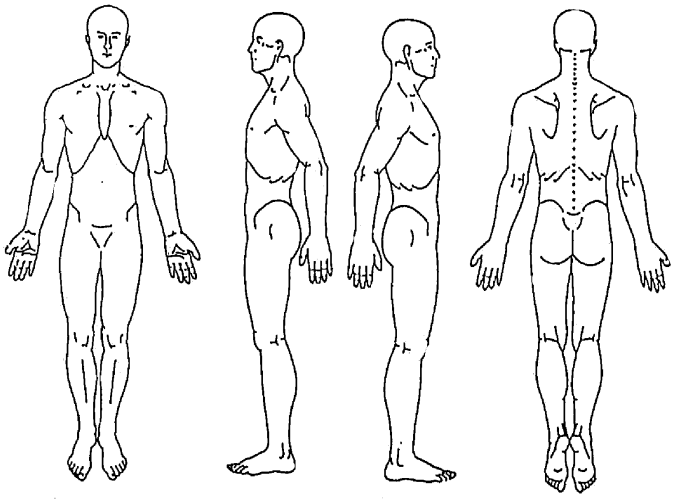
Surgery: _____

Medications: _____

Accidents/Traumas: _____

Family History: _____

_____



Please outline on the diagram the area of your discomfort and any radiation of pain