For Mother to complete:

1. Tell us about your pregnancy:

Did you carry to full term? ____________________________________________________________

Describe any complications and when they occurred: ___________________________________________

__________________________________________________________

Did you consume alcohol during your pregnancy? _______________ How much? ________________________

Did you smoke? _______________ How much? _______________ How long? ________________________

Did you take any medication during your pregnancy? _______________ For what? ________________________

What type(s)? __________________________________________

Any exposures to ultrasound? ________________________ How many? ____________________________

2. Tell us about the delivery and birth of this child:

Did you use a midwife? ___________ Hospital? ___________ Obstetrician? ________________

Did you have a C-Section? ___________ Were forceps used? _______ Vacuum Extraction? ___________

Were you induced? ___________ Did you have an Epidural? ___________ Was it a difficult birth? ___________

What was the baby’s APGAR score? ________________ At 5 minutes? _________________________

3. Tell us More:


4. As a baby/toddler (birth to 4 years) did any of the following occur?

____ Fall from a change table
____ Tumble down stairs
____ Fall out of crib
____ Involved in car accident
____ Fall off playground equipment
____ Play in jolly jumper
____ Frequent crying spells
____ Frequent fevers
____ Frequent bouts of diarrhea
____ Constipation
____ Sleeping problems
____ Frequent colds
____ Colic
____ Did not gain weight
____ Reaction to vaccinations
____ Other __________________________

Please explain those indicated above: ________________________________________________________
5. As a young child (5 to 12 years) did any of the following occur?

- [ ] Fall from a tree
- [ ] Bed wetting
- [ ] Fall off a bicycle
- [ ] Hyperactivity/Autism
- [ ] Fall off playground equipment
- [ ] Learning difficulties
- [ ] Sports accident
- [ ] Asthma
- [ ] Car accident
- [ ] Allergies
- [ ] Stomach pains
- [ ] Leg/knee pains
- [ ] Scoliosis
- [ ] Other _________________

Please explain those indicated above: ____________________________________________________________________________

6. Tell us about any vaccinations your child has had: ____________________________________________________________________________

Did they have reactions to any of these? ________________________________________________________________________________

Were you told that you had a choice in vaccinating your child? ________ YES ________ NO

Would you like information on another side of the issue? ________ YES ________ NO

7. As a child or adolescent, has your child experienced any of the following?

- [ ] Headaches
- [ ] Numbness in arms/hands
- [ ] Foot/ankle/knee pains
- [ ] Dizziness
- [ ] Arm/wrist pains
- [ ] Tingling in arms/legs
- [ ] Ringing in ears
- [ ] Sleeping problems
- [ ] Neck/back pains
- [ ] Asthma
- [ ] Allergies
- [ ] Shoulder pains
- [ ] Hyperactivity
- [ ] Stomach problems
- [ ] Growing pains
- [ ] Fatigue
- [ ] Weight gain/loss
- [ ] Other _________________

Please explain those indicated above: ________________________________________________________________________________

8. Which of the problems you have checked is the worst? _______________________________________________________________________

Is this problem: Constant ________ Intermittent ________ Occasional ________ Cyclic ________

9. How long has it persisted? _________________________________________________________

10. When is it at its worst and how does it make your child feel? _________________________________

11. What have you done about it that has not worked? ___________________________________________

12. What makes it worse? ______________________________________________________________________________
13. What effect does this problem have on your child’s body functions? 

On his/her participation in daily activities?

14. Describe any hospital stays: 

15. Approximately how many times have antibiotics been prescribed and for what conditions? 

16. List any medications your child is currently taking: 

17. Is there anything else you feel we should know?
# Welcome

## Patient Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Address</td>
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<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

**Sex:** □ M  □ F  □ A  
Age________

**Manitoba Medical #** ____________________________  **Personal Health ID #** ____________________________

**Birthdate** ____________________________

**Home Phone** ____________________________

**Parent Name(s)** ____________________________

**Parent Work Phone** ____________________________  **Parent Cell Phone** ____________________________

**Referred to our office by** ____________________________

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**Reason for consulting our office** ____________________________

**How long have they had this condition?** ____________________________

**Is condition due to an accident?** □ No  □ Yes  **Date of Accident** ____________________________

**Are you claiming under MPI?** □ No  □ Yes  **Claim #** ____________________________

**What treatment have they already received for their condition?**

□ Medications  □ Surgery  □ Physical Therapy

□ Chiropractic Services  □ None  Other ____________________________

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Please check the **One** choice that most closely describes your current goals for your child’s health/well-being:

□ I am only concerned about relief of a particular symptom

□ I am only concerned about relief of a particular symptom and preventing its return

□ I want optimum health and well-being on every level available for my child

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I understand that payment is due at the time of service, unless other arrangements have been made and agreed upon in writing.

**Signature of Parent/Guardian** ____________________________  **Date** ____________________________