DR. RENEE LAFRAMBOISE B.SC., D.C.

Personal Information

Child's Name: _____ Gender: ☐M ☐F

Date of Birth: _____ Age: ____

Parents Name(s): _____ Number of siblings: _____

Address: _____

*City*_____

*Province*_____

*Postal Code*_____

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____

Is it okay to use your email to send reminders/office information? ☐ Yes ☐ No

Have you or your child ever received chiropractic care before? ☐ Yes ☐ No

Were you pleased with the care you received? ☐ Yes ☐ No

How did you hear about our office?

_____

What is the goal of your visit? ☐ Health maintenance/optimization ☐ Health problem ☐ Both

Is your child receiving care from other health care professionals? ☐ Yes ☐ No

If so, please name them and their specialty:

_____

Who is your family's primary care physician?

_____

Address: _____ Phone: _____

*Please list any drugs or medications your child is taking:

_____

*Please list any vitamins/supplements/homeopathics/other your child is taking?

_____

*Please list any allergies or sensitivities your child has?

_____

Health Information

What brings your child to our office?_____

When did the signs or symptoms first appear? _____

How did it start? ☐ Suddenly ☐ Gradually ☐ Post-injury

Is it ☐Getting worse ☐improving ☐intermittent ☐Constant ☐Not Sure

What makes it *better*? _____

What makes it *worse*? _____

Has your child ever had something similar before? ☐Yes ☐No

Please explain; _____

Has your child ever been treated for this before? ☐Yes ☐No ☐Not Sure

How does this affect this child's:

Ability to sleep?_____

Ability to eat?_____

Behaviour?_____

Ability to play?_____

Does your child eat well? ☐Yes ☐No

Does your child have regular bowel/bladder movements? ☐Yes ☐No

Is your child able to have bowel/bladder movements without difficulty? ☐Yes ☐No

Does your child sleep well? ☐Yes ☐No

On average, how many hours of sleep does your child get? _____

Has your child been in a motor vehicle accident? ☐Yes ☐No

If yes, were they hospitalized? ☐Yes ☐No

Does your child play sports? ☐Yes ☐No

If yes, please list the sports _____

Has your child been hospitalized? ☐Yes ☐No

If yes, please list the year and reason_____

Has your child had any injuries? (Accidents, fractures, falls, etc)? ☐Yes ☐No

If yes, please describe the injury and the year it occurred

_____

Some symptoms are manifestations of other health concerns, though seemingly unrelated. Please check off all that apply:

Musculoskeletal	**Cardiovascular/Respiratory**	**Gastro-Intestinal**	**General**
☐Low back pain	☐Shortness of breath	☐Poor appetite	☐Fatigue
☐Pain between shoulders	☐Irregular heartbeat	☐Excessive thirst	☐Irritability
☐Neck pain	☐Heart problems	☐Frequent nausea	☐Allergies
☐Headaches	☐Pneumonia_ _	☐Frequent diarrhea	☐Poor sleep
☐Arm pain	☐Bronchitis	☐Frequent constipation	☐Poor balance
☐Leg pain	☐Asthma	☐Bloating/Gas	☐Poor concentration
☐Jaw pain/clicking	**Eyes/Ears/Nose/Throat**	☐Abdominal cramps	☐High stress
☐Growing pains	☐Vision problems	☐Heartburn	☐Fever
☐Scoliosis	☐Loss of smell	☐Reflux	☐Frequent colds
Nervous system	☐Dental problems	☐Bedwetting	☐Difficulty breastfeeding
☐Fainting	☐Sore throat	☐Skin Rashes	
☐Convulsions	☐Earache/infection		
☐ADD/ADHD	☐Hearing loss		
☐Colic	☐Sinus congestion		

Pregnancy/Birth History

Did mother smoke during the pregnancy? ☐ Yes ☐ No

Drink alcohol? ☐ Yes ☐ No

On a scale of 1 to 5, how stressful was the pregnancy for the mother? ____/5

Did the mother have any illnesses or immune issues during the pregnancy? ☐ Yes ☐ No

If yes, please explain (include use of antibiotics, medications or interventions):

_____

List any drugs/medications (including over the counter and vaccines) taken during pregnancy?

_____

List any supplements taken during pregnancy (including brand)?

_____

Was your child exposed to ultrasound during pregnancy? ☐ Yes ☐ No

What were the medical reasons for the ultrasounds (if given)?

_____

Any problems during pregnancy with this child? ☐Fall onto buttocks ☐Low back pain ☐Gestational diabetes ☐Hypertension ☐Car accident ☐Other

_____

What position was your child in during birth? ☐Vertex (head down) ☐Breech (bum down)

Other_____☐Posterior (face-up) ☐Transverse ☐Face / Brow first

Child's birth was ☐At home ☐At A Birthing center ☐At The Hospital

Did you go with a ☐Midwife ☐Obstetrician ☐Family Physician

What was the name of your health care provider?_____

Child's birth was :

☐Natural vaginal without intervention/manual extraction/pain medication

☐Vaginal with interventions

☐ Induction or Pitocin ☐Pain medication ☐Epidural ☐Episiotomy

☐ Vacuum extraction ☐Forceps ☐Manual extraction

☐Other: _____

☐C-section

☐Scheduled ☐Emergency

Please list reasons for any interventions/complications:

_____

Any evidence of birth trauma to the infant? ☐bruising ☐odd shaped head ☐stuck in birth canal ☐fast or excessively long birth ☐respiratory depression ☐cord around neck

Child's birth weight: ____pounds Child's birth length ___ inches APGAR score: ___/10

Growth & Development

What was your child's gestational age at birth: _____ weeks

At what age did your child;

Respond to sound ____ Follow an object____ Hold head up ____ Vocalize ____

Sit alone ____ Teeth ____ Crawl ____ Walk ____

Is/was your child breastfed? ☐ Yes ☐No If yes, for how long? _____

Is/was your child formula fed? ☐ Yes ☐ No What type? _____ What age? _____

At what age was your child introduced to cow's milk? ____ Solid foods at age? _____

Please list any food or juice intolerances?

_____

Do you have any pets at home? ☐ Yes ☐ No

Do you have anyone that smokes at home? ☐ Yes ☐ No

Has your child received any antibiotics? ☐ Yes ☐ No How many times? _____

What was/were the reason(s) for the antibiotics?_____

Does your child get a "cold" often (or flu-like symptoms)? ☐ Yes ☐ No If yes, how many times a year?_____

Any difficulty with breastfeeding? ☐ Yes ☐ No

If yes, please explain; _____

Any difficulty with bonding? ☐ Yes ☐ No

If yes, please explain; _____

Any behavioral problems or concerns? ☐ Yes ☐ No Please explain;_____

Any night terrors, sleepwalking or difficulty sleeping? ☐ Yes ☐ No

Please explain; _____

How many hours of sleep does your child get per night? ____

At what age did they sleep through the night (5 hours)? ____

How does your child sleep? ☐Stomach ☐Back ☐Side

At what age did your child begin daycare? _____

How many hours of TV does your child watch per week?_____

At what age did this child:

Hold up head _____ Sit alone _____Crawl _____

Stand _____ Walk alone _____

Are you concerned at all with your child's development thus far? ☐ Yes ☐ No

If yes, please explain;

_____

Vaccination History

☐I have chosen not to vaccinate this child

☐I have not decided yet

☐Full schedule suggested by my MD

Have you chosen any additional vaccines for this child? ☐No ☐Chicken Pox ☐Flu Vaccine

☐Other _____

Have you chosen to opt out of any vaccines for any reason?:_____

Has your child ever had any known side effects to any vaccines? ☐No ☐Yes

If yes, please give dates, vaccine type and side effects:

_____

Family History

Does your family have any of the following conditions?

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Depression

☐ Back problems ☐ Liver disease ☐ High blood pressure ☐ High cholesterol

☐ Lung problems ☐ Scoliosis ☐ Neck problems ☐ Osteoporosis

☐ Seizures ☐ Rheumatoid Arthritis ☐ Other: _____

Thank you for your patience and cooperation in completely filling out this form. The details allow us to perform a specific physical examination, and monitor your child's progress through the stages of care. If you have any questions, please feel free to ask.

Consent for Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are consenting to a chiropractic examination of your child. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctors named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a "hands-on" approach so that we can best assess your child's health. The examination may also include a computerized sEMG analysis, as well as necessary x-rays if indicated (rare).

_____

Child Name

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

_____

Doctor Witness Signature