

**West Lethbridge Family Chiropractic  
Pediatric New Patient Form**

Full Name of Child: \_\_\_\_\_ Alberta Health Care #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mom's Work Phone: \_\_\_\_\_ Dad's Work Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

If Parents are separated, do you have health care custodial rights for this child? (Please Initial) Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Number of Siblings: \_\_\_\_\_

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Current Weight \_\_\_\_\_ Current Length \_\_\_\_\_

Third Trimester Presentation: Vertex/"Normal": \_\_\_\_\_ Breech: \_\_\_\_\_ Transverse: \_\_\_\_\_ Face/Brow: \_\_\_\_\_

Type of Birth: Normal Vaginal: \_\_\_\_\_ Forceps: \_\_\_\_\_ Cesarean: \_\_\_\_\_ Suction Cap/Vacuum: \_\_\_\_\_

Location of Birth: \_\_\_\_\_

Problems during pregnancy (Please describe): \_\_\_\_\_  
\_\_\_\_\_

Problems during labour and delivery (Please describe): \_\_\_\_\_  
\_\_\_\_\_

Congenital Anomalies/ Defects? No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes, please explain): \_\_\_\_\_

Infant Feeding: Breast \_\_\_\_\_ Bottle \_\_\_\_\_ If bottle, which formula? \_\_\_\_\_

Number of hours sleeping per night: \_\_\_\_\_ Quality of Sleep: Good: \_\_\_\_\_ Fair: \_\_\_\_\_ Poor: \_\_\_\_\_

Family doctor: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Purpose of last visit: \_\_\_\_\_

Immunization History: \_\_\_\_\_

Number of doses of antibiotics your child has taken: During the last 6 months: \_\_\_\_\_ During his/her lifetime: \_\_\_\_\_

Has your child ever been to a chiropractor before? No \_\_\_\_\_ Yes \_\_\_\_\_ Date and Purpose of Visit: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever been treated on an emergency basis? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**If your child is here for a specific condition, please explain in the following spaces. If not, you may skip to next page.**

Present problem: \_\_\_\_\_

Date this condition was first noticed: \_\_\_\_\_

Did something specific cause this condition? (Please describe) \_\_\_\_\_

Since the problem started, is it... Improving \_\_\_\_\_ About the Same \_\_\_\_\_ Getting Worse \_\_\_\_\_

Does anything make it better? \_\_\_\_\_

Does anything make it worse? \_\_\_\_\_

Other health professionals seen for this problem (please list names and dates if applicable)

Chiropractor \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Other \_\_\_\_\_

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Has this child ever suffered from:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> headaches      | <input type="checkbox"/> orthopedic problems | <input type="checkbox"/> digestive disorders | <input type="checkbox"/> behavioural problems                       |
| <input type="checkbox"/> dizziness      | <input type="checkbox"/> neck problems       | <input type="checkbox"/> poor appetite       | <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> fainting |
| <input type="checkbox"/> arm problems   | <input type="checkbox"/> stomach aches       | <input type="checkbox"/> hernia              | <input type="checkbox"/> seizures/convulsions                       |
| <input type="checkbox"/> leg problems   | <input type="checkbox"/> reflux              | <input type="checkbox"/> muscle pain         | <input type="checkbox"/> heart trouble                              |
| <input type="checkbox"/> joint problems | <input type="checkbox"/> constipation        | <input type="checkbox"/> growing pains       | <input type="checkbox"/> chronic earaches                           |
| <input type="checkbox"/> back pain      | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> sinus trouble       | <input type="checkbox"/> anemia                                     |
| <input type="checkbox"/> poor posture   | <input type="checkbox"/> diabetes            | <input type="checkbox"/> asthma              | <input type="checkbox"/> Allergies to _____                         |
| <input type="checkbox"/> colds/flu      | <input type="checkbox"/> trouble walking     | <input type="checkbox"/> scoliosis           | <input type="checkbox"/> Allergies to _____                         |
| <input type="checkbox"/> colic          | <input type="checkbox"/> broken bones        | <input type="checkbox"/> bed wetting         | <input type="checkbox"/> Allergies to _____                         |

Is there any other health condition your child is dealing with? \_\_\_\_\_

Please list any medications your child is currently taking: \_\_\_\_\_

Has this child ever sustained injuries in an auto accident? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Has this child ever suffered from a fall? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Has your child ever had any surgery? \_\_\_\_\_

Is there anything else you would like to discuss about your child with Dr. Heilman? \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine this child for further evaluation.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date