Dr. Lori Broker
Patient Information Sheet
0 – 6 yrs.

Today's date: _____

Name: _____ Birth date (M/D/Y): _____ Age: _____
P.O. Box: _____ Parents Home phone: _____
Address: _____ Parents Cell phone: _____
City: _____ Parents E-mail address: _____
Province: _____ School/Daycare: _____
Postal Code: _____ Care Card#: _____
Physician: _____
Parents: _____
_____

Siblings (name and age):
_____
_____
_____

Who may we thank for referring you to our office? _____
_____

Past chiropractic care: (yes/no; if yes, Dr.(s) name/location/last visited) _____
_____
_____

Current drugs/medication: _____

Reason for consulting this office: _____
_____
_____

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COMPREHENSIVE HEALTH PROFILE

Why this form is important

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce heath problems. Please, complete this form as thoroughly as possible and the doctor will review it with you.

HISTORY OF BIRTH

What was the child's gestational age at birth? _____ wks – Birth weight: _____ lb. _____ oz. – Birth length: _____ in.

Was your child's birth: ❑ at home ❑ in a birthing centre ❑ in a hospital

Was the birth considered: ❑ medical ❑ midwife

What was the duration of the labour and birth? _____ hours

Was the child born: ❑ Cephalic (head first) ❑ Breech (feet first)

Were there any complications? ❑ Yes ❑ No If yes, please explain _____

_____

Please, check any assistance, which was used during the birth:

❑ Forceps ❑ Vacuum Extraction ❑ C-Section ❑ Episiotomy

Was labour: ❑ Spontaneous ❑ Induced

Were medications or epidurals given to the mother during birth? ❑ Yes ❑ No

If yes, what was given? _____

_____

PRESENT HEALTH COMPLAINTS/CONCERNS

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: ❑ Occasional ❑ Frequent ❑ Constant ❑ Intermittent

Does this problem radiate? ❑ Yes ❑ No If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? ❑ Yes ❑ No If yes, when?_____

Does this interfere with the child's ❑ Sleep ❑ Daily Routine ❑ Eating ❑ General personality

Is this becoming worse? _____

Have other professionals been seen for this condition? _____

Result with that treatment? _____

_____

Do you consider the child's sleeping pattern normal? ❑ Yes ❑ No If no, explain _____

Does your child have any problems with bed-wetting? ❑ Yes ❑ No

Often seemingly unrelated symptoms can manifest as other health concerns:

Please, check if your child has had any of the following

❑ Depression	❑ Asthma	❑ Sinus congestion	❑ Stiffness
❑ Fainting	❑ Bronchitis	❑ Sore throats	❑ Weakness
❑ Fatigue	❑ Light sensitivity	❑ Dental problems	❑ Growing pains
❑ Headaches	❑ Urinary problems	❑ Ear pain/ Infections	❑ Reduced mobility
❑ Loss of balance	❑ Weight loss	❑ Bloating/Gas	❑ Muscle cramps
❑ Poor coordination	❑ Pneumonia	❑ Weight gain	❑ Sleeping problems
❑ Vision changes	❑ Face flushed	❑ Frequent colds	❑ Constipation
	❑ Difficulty breathing	❑ Allergies	❑ Diarrhea

❑ Other: _____

FAMILY HEALTH HISTORY

Please, note any health issues with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

PHYSICAL STRESSORS

Any significant falls or trauma to the mother during pregnancy? ❑ Yes ❑ No ❑ Unsure

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

For the child, were there any falls from couches, beds, change tables, etc? ❑ Yes ❑ No ❑ Unsure

Any hospital visits for concussions, possible fractures or other traumas? ❑ Yes ❑ No ❑ Unsure

Have there been any surgeries? ❑ Yes ❑ No If yes, please explain: _____

Is a backpack worn? ❑ Yes ❑ No If yes, is it ❑ heavy or ❑ light

Does your child participate in sports? ❑ Yes ❑ No _____

Any hobbies or activities, which require prolonged, awkward or repetitive postures? (i.e violin, gymnastics, etc.) ❑ Yes ❑ No ❑ Unsure

Sport history injuries: Year: _____ Injury: _____

_____

CHEMICAL STRESSORS

Was the child breast-fed? ❑ Yes ❑ No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Cow's milk was introduced at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food/Juice intolerance? ❑ Yes ❑ No If yes, what type? _____

During pregnancy, did the mother, smoke ❑ Yes ❑ No If yes, how much? _____

drink ❑ Yes ❑ No If yes, how much? _____

Any illnesses during the pregnancy? ❑ Yes ❑ No If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ❑ Yes ❑ No If yes, what supplements? _____

_____

Any drugs during the pregnancy? ❑ Yes ❑ No If yes, what drugs? _____

_____

Any ultrasounds? ❑ Yes ❑ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (i.e. Amniocentesis, CVS, etc)? ❑ Yes ❑ No

Any pets at home? ❑ Yes ❑ No If yes, what kind(s)? _____

Any smokers in the home? ❑ Yes ❑ No

VACCINATION HISTORY

Vaccination and age given? _____

Any negative reactions? ❑ Yes ❑ No If yes, what were they? _____

_____

Any antibiotics given? ❑ Yes ❑ No If yes, reason? _____

PSYCOSOCIAL STRESSORS

Any difficulties with lactation? ❑ Yes ❑ No If yes, what were they? _____

Any problems with bonding? ❑ Yes ❑ No If yes, what were they? _____

Any behavioural problems? ❑ Yes ❑ No If yes, what were they? _____

Any of the following: ❑ Night terrors ❑ Sleep walking ❑Difficulties sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ❑ Yes ❑ No

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below._____

_____

_____