Child Initial Patient Forms

Name: _____

6 Digit MB Health #: _____ 9 Digit MB Health (PHIN): _____

Address: _____City: _____ Postal Code: _____

Phone (H): _____ Age: ____ Birth date: (M)____/(D)____/(Y)_____ Sex: M F

Reason for consulting our office: _____

Markham Chiropractic Centre may use this information to send you wellness tips and other offers.

THE BEGINNING YEARS (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your abilities.

Yes	No	Childhood (to age 17)	Patient Comment if Yes	Chiropractor Comments
__	__	Have you ever had any childhood illnesses?	_____	_____
__	__	Have you had any serious falls?	_____	_____
__	__	Do you play youth sports?	_____	_____
__	__	Do you take/use any medications?	_____	_____
__	__	Have you had any surgeries?	_____	_____
__	__	Have you fallen/jumped from a height over three feet?	_____	_____
__	__	Were you involved in any car accidents?	_____	_____
__	__	Is there any prolonged use of medicine?	_____	_____
__	__	Have you suffered other traumas(physical/emotional)?	_____	_____
__	__	Were there any difficulties during your birth?	_____	_____
__	__	Are/were you under regular chiropractic care?	_____	_____

Please check any you have ever had in the past, even if they do not seem related to your current problem.

1) Balance Problems (loss of balance, dizziness, fainting) __

2) Digestive System (stomach upset, heartburn, constipation, diarrhea, ulcers) __

3) Musculoskeletal System (pins and needles in face, arms and legs, back pain, buzzing in ears, headaches, neck pain, neck stiffness) __

4) Mood Changes (mood swings, nervousness, depression) __

5) General Health Issues (fatigue, sleeping problems) __

6) Loss of Senses (smell, taste, vision, light bothers eyes) __

7) Renal System (problem urinating, kidney, bladder) __

List any medications you are taking and for what reason: _____

Have you had previous chiropractic care? _____ Where? _____ When? _____

Why? _____ Dr: _____ Were X-rays taken? _____

Have you been in an automobile accident? __ NO __ Past year __ 2-5 years __ Over 5 years

Describe the accident: _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Mother _____

Father _____

Siblings _____

Others _____

How did you hear about our office? __ Friend __ Family __ Newspaper __ Sign __ Radio __ Other _____

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

The statements made on these forms are accurate to the best of my recollection and I agree to allow Markham Chiropractic Centre to examine me, make diagnostic images of me, treat me, and do everything necessary, in accordance with the law, for my chiropractic care and management. I also understand and agree that I am solely responsible for payments on all services rendered that are not covered by Manitoba Medicare, Workers Compensation or Autopac.

_____ _____

Signature of Patient/Guardian Date

NOTES