CompleteHealth

Child Intake - Ages 5-12

Welcome to Complete Health!

This form is to provide your doctor with a detailed health history to better manage your case. Please complete the form to the best of your knowledge.

Email/text notifications

Name: ______________________________________ Date: ______________________________________

E-mail: ____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail for appointment reminders and information regarding your wellness.

Do you consent? □ YES □ NO ____

Please sign name here

Cancellation Policy

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.

We understand some circumstances are beyond your control, so please discuss with us when cancelling.

No shows will be charged the full treatment amount.

____

Patient Signature

Child's Personal Information

Date: __________________________ Alberta Healthcare Number: ______________________________________

First Name: _______________________________ Last Name: ____

Parent A Name: _____________________________ Parent A Phone #: _________________________________

Parent B Name: ______________________________ Parent B Phone #: _______________________________

DOB: __________________________ Age: _____________________ □ Male □ Female □ Other

Num. of siblings: ________________ Child's Weight: _____________ Child's Height: ________________

Address: _______________________________ City: _____________________ Postal Code: ________________

How did you hear about Complete Health? ____

Have you ever seen a Chiropractor? □ YES □ NO

Who? ____ Date of last adjustment? ________________________

Pediatrician / Family Medical Doctor: ____

Date of last visit to Medical Doctor: ______________________ Purpose:________________________________

Vaccination history: ____

Childhood Diseases: □ Chickenpox □ Rubella □ Mumps □ Measles □ Whooping Cough

Other: ____

What operations have you had? When? ____

____

Have you ever been seen in Emergency? □ YES □ NO Why: ____

Have you ever been hospitalized? □ YES □ NO Why: ____

Have you ever had any bad accidents or falls? □ Yes □ No If so, when? ____________________________

Broken/Fractured bones? □ Yes □ No Which ones? ____

Type of Birth: □ Normal Vaginal □ Forceps □ Cesarean Hospital: _________________________________

Problems during pregnancy:____

Problems during labor or delivery:____

Length of labor: ____________________ Congenital abnormalities or defects: __________________________

Number of hours of sleep per night: _________________ Quality of sleep: □ Good □ Fair □ Poor

Purpose of this appointment: ____

Explain how complaint occurred: ____

When did this condition begin?____

Condition has persisted for: □ DAYS □ WEEKS □ MONTHS □ YEARS

What activities make this condition better?____

What activities make this condition worse? ____

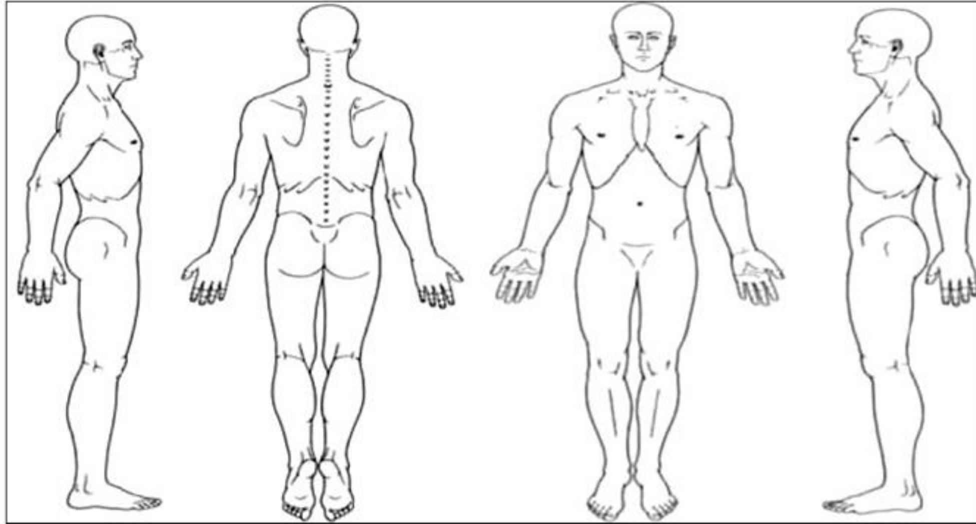
Have you seen anyone else for this condition? If so, whom?____

Medications/supplements/vitamins you are taking: ____

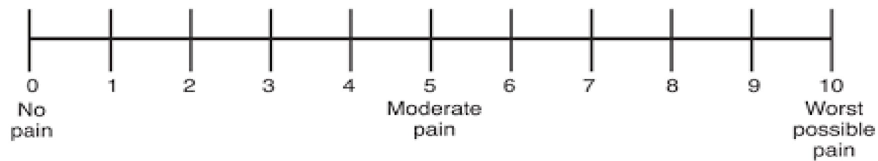
____

____

DRAW YOUR PAIN- Mark in the areas on the diagrams where you have pain.



RATE YOUR PAIN ON THIS SCALE- Mark with an X



Health Systems Review Please check each of the following diseases or conditions that you have now or have had in the past

- ❑ Allergy
- ❑ Dizziness
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of sleep
- ❑ Ulcers
- ❑ Nervousness / Depression
- ❑ Numbness
- ❑ Arthritis
- ❑ Hyperactivity
- ❑ Foot trouble
- ❑ Low back pain
- ❑ Chronic fatigue syndrome
- ❑ Neck pain or stiffness

Tingling or numbness in:

- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

- ❑ Poor posture
- ❑ Sciatica
- ❑ Spinal curvatures
- ❑ Swollen joints
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficult digestion
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Asthma
- ❑ Colds
- ❑ Deafness
- ❑ Eye pain
- ❑ Ear noises
- ❑ Venereal disease
- ❑ Heart disease
- ❑ Enlarged thyroid
- ❑ Failing vision

- ❑ Tuberculosis
- ❑ Bruise easily
- ❑ Hay fever
- ❑ Nosebleeds
- ❑ Sinus Infection
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ Anemia
- ❑ Chest pain
- ❑ Stroke
- ❑ Difficult breathing
- ❑ Pleurisy
- ❑ Spitting
- ❑ Swelling of ankles

- ❑ Itching
- ❑ Varicose veins
- ❑ Bed-wetting
- ❑ Frequent urination
- ❑ Kidney infection or stone
- ❑ Stomach Aches
- ❑ Cramps or backache
- ❑ Excessive menstrual flow
- ❑ Behavioral Problems
- ❑ Irregular cycle
- ❑ Chronic Ear Aches
- ❑ Growing Pains
- ❑ Polio
- ❑ Diabetes
- ❑ Aids / HIV positive
- ❑ Hypoglycemia
- ❑ Cancer
- ❑ Psoriasis / Eczema

AUTHORIZATION FOR CARE OF A MINOR

The Informed Consent must disclose, to the patient or the guardian of a minor patient, the nature of the proposed treatment or procedure and any potential risks including those that may be of a special or unusual nature.

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

Signed: ___________________________________ Date: ___________________________________

I understand that Chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulses to the involved tissue, thus allowing the body it's best chance of healing itself. I give the doctors and assistants at Complete Health Chiropractic and Massage full permission to render care to myself and/or my family.

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