Muller Chiropractic
We've got your back

Patient Name: _____ Date: day/month /year

Dear New Patient,

Welcome to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient name: _____Gender (F)(M)(other) Age: _____ Date of Birth: day/month /year

Parents/ Guardians: _____

Address:_____City: _____ Postal Code: _____

Phone: Home _____ / Cell_____ Email address: _____

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

Health History: Misaligned vertebrae, pinched nerves in the spine, and/or unbalanced nerve system can affect the child's health.

What is your purpose for contacting us? _____

Other Doctors seen for this condition and course of treatment: _____

Has your child suffered from any of the following in the past six months?

☐ Ear Infections	☐ Tonsilitis	☐ Asthma/ Allergies	☐ Dizzy/Clumsy	☐ Digestive problems
☐ Seizures	☐ ADHD	☐ Learning Difficulties	☐ Bed Wetting	☐ Chronic Colds
☐ Fevers	☐ Colic	☐ Temper Tantrums	☐ Sleeping Difficulties	☐ Headaches
☐ Growing Pains	☐ Back Problems	☐ Recurring Falls	☐ Other:	

Previous Chiropractor: _____Date of last visit: _____ Reason: _____

Paediatrician: _____Date of last visit: _____Reason: _____

Number of doses of antibiotics taken in past 6 months: _____ In lifetime: _____Reason: _____

Number of doses of prescription medications taken in past 6 mos: _____ in Lifetime: _____ Reason: _____

List of current medication and reason:_____

Vaccination History: _____Family History of Disease/Illness: _____

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Patient Name: _____ Date: day/month /year

Prenatal and Birth History: Birth trauma can produce some of the first spinal problems in the delicate spine of a newborn.

Name of Midwife or Obstetrician: _____

Any complications during your pregnancy: (Y) (N) Explain: _____

Ultrasounds during pregnancy: (Y) (N) Number: _____ Other exams done: _____

Did you smoke and/or consume alcohol during your pregnancy: (Y) (N)

Any of the following used in the delivery? ☐ Labour Induction ☐ Epidural ☐ Forceps ☐ Vacuum Extraction ☐ Other:_____

Were there any complications during your delivery? (Y) (N) Explain: _____

Birth Weight: _____ Birth Length: _____ APGAR at birth: _____at 5minutes:_____

Feeding History: If you have any concern or difficulty with breastfeeding, please let us know and a refer to a specialist can be arranged.

Was your child breastfed? (Y) (N) For how long? _____ Any problems with breastfeeding?_____

Was your child formula fed? (Y) (N) For how long?_____ Type/Brand: _____

Age when started solid food: _____ Type of food: _____Age when started cow's milk? _____

Does your child have any food or drink allergies/intolerances? (Y) (N) Type: _____

Developmental History: Many childhood falls can produce long-term spinal misalignments that may surface many years later in life.

Has your child ever had a major fall (change table, crib/bed, tree) or a car accident? (Y) (N) Date: _____Explain: _____

_____

Has your child ever had a sports injury or been involved in a high impact or contact sport (soccer, football, hockey, gymnastics, cheerleading, martial arts)? (Y) (N) Date: Explain: _____

Has your child ever had surgery or been seen on an emergency basis? (Y) (N) Date: _____ Reason: _____

Female Patients: Menarche? (Y) (N) Age of first period: _____Is the period regular? (Y) (N) Any pain/discomfort? (Y) (N) _____

Authorization for care of a minor:

I, _____(print name of parent/guardian), hereby authorize Dr. Danny Muller to evaluate and administer care to my child as she deems necessary. I clearly understand and agree that I am personally responsible for payment of my child's fees. I understand my obligation to give further notice if the appointment needs to be rescheduled or cancelled, which should be done by 2:00 p.m. on the day prior to my scheduled appointment. If prior notification is not given, a $30 fee is applied for the missed appointment.

Signed: _____ Witnessed: _____ Date: D / M / Y