

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: _____ Age: _____ Gender (F) (M) (other)

Date of Birth: day/month/year Due date: 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?

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Tonsilitis	<input type="checkbox"/> Asthma/ Allergies	<input type="checkbox"/> Dizzy/Clumsy	<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Seizures	<input type="checkbox"/> ADHD	<input type="checkbox"/> Learning Difficulties	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Chronic Colds
<input type="checkbox"/> Fevers	<input type="checkbox"/> Colic	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Sleeping Difficulties	<input type="checkbox"/> Headaches
<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Recurring Falls	<input type="checkbox"/> 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: _____

Extended Health Insurance - Direct Billing: Direct billing may be available to you. Please provide your insurance information: Name of insurance _____ Policy number _____ Member ID _____

Name of insured member: _____ Relationship to the child: _____ Insured member date of birth _____

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: _____

Premature baby? (Y) (N) If yes, How early? _____ 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 5 minutes: _____

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