Infant, Child & Adolescent Health History Intake Form

Last Name: ______________________ Given Name: ______________________

Birthdate (D/M/Y): ____________ Gender: ☐ F ☐ M

Parent 1: ______________________ Parent 2: ______________________

Address: ______________________ Apt. No. ________

City: ____________ Province: ____________ Postal Code: ____________

Home # (____) ____________ Cell # (____) ____________ Work # (____) ____________

E-mail (for appointment reminders and health newsletters only): ______________________

TELL US ABOUT YOUR PREGNANCY:

Did you carry to full term? ______________________

Describe any complications and when they occurred:

____

____

TELL US ABOUT YOUR DELIVERY AND BIRTH OF THIS CHILD:

	Y	N		Y	N
Did you use a midwife?	☐	☐	Were you induced?	☐	☐
Hospital?	☐	☐	Did you have an Epidural?	☐	☐
Obstetrician?	☐	☐	Was it a difficult birth?	☐	☐
Did you have a C-Section?	☐	☐	Baby's APGAR Score at birth?	______	
Were forceps used?	☐	☐	Baby's APGAR Score at 5 minutes?	______	
Vacuum Extraction?	☐	☐			

TELL US MORE:

Did you breastfeed? ☐ Y ☐ N How long? ____________ What formula after? ____________

Did you consume alcohol during your pregnancy? ☐ Y ☐ N How much? ____________

Did you smoke? ☐ Y ☐ N How much? ____________ How long? ____________

Did you take any medication during your pregnancy? ☐ Y ☐ N For what? ____________

What type(s)? ______________________

Any exposures to ultrasound? ☐ Y ☐ N How many? ______________________

Annex Family CHIROPRACTIC
EMPOWERING YOU FOR OPTIMAL HEALTH

Dr. Joshua Gelber, D.C.
Principled Wellness Chiropractor

416 967 4466 • annexfamilychiropractic.com
206-738 Spadina Ave, Toronto, ON M5S 2J8

Health Profile

AS A BABY/TODDLER, (BIRTH TO 4 YEARS), DID ANY OF THE FOLLOWING OCCUR?

- ☐ Fall from a change table
- ☐ Frequent crying spells
- ☐ Tumble down stairs
- ☐ Frequent fevers
- ☐ Fall out of crib
- ☐ Frequent bouts of diarrhea
- ☐ Involved in car accident
- ☐ Constipation
- ☐ Fall off playground equipment
- ☐ Sleeping problems
- ☐ Play in A Jolly Jumper @ _____ mos/yrs
- ☐ Frequent colds
- ☐ Frequent ear infections
- ☐ Colic
- ☐ Tonsillitis
- ☐ Did not gain weight
- ☐ Reaction to vaccination
- ☐ Other: ______________________________

AS A YOUNG CHILD, (5-12 YEARS), HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING:

- ☐ Fall from a tree
- ☐ Bed wetting
- ☐ Fall of a bicycle
- ☐ Hyperactivity/Autism
- ☐ Fall of playground equipment
- ☐ Learning difficulties
- ☐ Sports accident
- ☐ Asthma
- ☐ Car accident
- ☐ Allergies
- ☐ Stomach pains
- ☐ Leg/knee pains
- ☐ Scoliosis
- ☐ Other: ______________________________

AS A CHILD OR ADOLESCENT, HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING:

- ☐ Headaches
- ☐ Numbness in arms/hands
- ☐ Foot/ankle/knee pains
- ☐ Dizziness
- ☐ Arm/wrist pains
- ☐ Frequent bouts of diarrhea
- ☐ Tingling in arms/legs
- ☐ Ringing in ears
- ☐ Sleeping problems
- ☐ Weight gain/loss
- ☐ Neck/back pains
- ☐ Asthma
- ☐ Allergies
- ☐ Shoulder pains
- ☐ Hyperactivity
- ☐ Stomach problems
- ☐ Growing Pains
- ☐ Fatigue
- ☐ Other: ______________________________

Which of the problems you have checked off is the worst? ________________________________

Is this problem: Constant ☐ Intermittent ☐ Occasional ☐ Cyclic ☐

How long has it persisted? ________________________________

When it is at its worst, how does it make your child feel? ________________________________

What have you done about it that has not worked? ________________________________

What makes it worse? ________________________________

What effect does this problem have on your child's body functions? ________________________________

____

On his/her participation in daily activities? ________________________________

Describe any hospital stays: ________________________________

____

Approximately how many times have antibiotics been prescribed and for what conditions?________________

____

List any medications your child is currently taking: ________________________________

To summarize, what is your purpose for this appointment?________________________________

Is there anything else you feel we should know? ________________________________

____

Signature of Parent or Guardian: ________________________________

Date: ________________________________

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Annex Family Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation (Nervous System Traffic Jam): A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our only practice objective is to eliminate a major interference to the expression of the body's internal power. Our method is specific adjusting to correct vertebral subluxations.

I, ____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept the potential for chiropractic care on this basis.

______________________________ ______________________________

Patient Signature/Guardian's Consent Date

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