Ajax Chiropractic & Wellness

314 Harwood Ave. South, Unit 20 Ajax, ON L1S 2J1 Phone # (905) 426-9004
Dr. Tanya Slapnicar Dr. Derek Ginter

Pediatric Intake Form

Parent/Guardian Name(s):____

Child's First Name:________________________ Child's Surname: ______________________

Address:____City:______________________

Postal Code: _________________ Parent's Contact Tel #: ______________________________

Parent's email address: ____

☐ Click here if you would not like to be contacted by email

Primary Language Spoken:______________________Child's Height:________Weight:_______

Please list any drugs/medications/vitamins/herbs/other, that your child is taking:

____

Current Health Conditions

Reason for your visit:

____

Has your child ever received care for this problem before? Yes No

If yes, please explain:

____

When did the condition(s) first begin?

____

How did the problem start?	Suddenly	Gradually	Post-injury
Is the condition:	Getting worse	Improving	Intermittent (on & off)
	Constant	Unsure	

What makes the problem better?

____

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What makes the problem worse?

____

Health Goals for Your Child

What are your top three health goals for your child?

1-____

2-____

3-____

What would you like to gain from chiropractic care?

Resolve existing conditions Overall wellness Both

Has your child ever visited a chiropractor before? Yes No

If yes, did it help?

____

Pregnancy & Fertility History

Any fertility issues? If yes, please explain:

____

Did mother smoke? If yes, please explain:

____

Did mother consume alcohol? If yes, please explain:

____

Was mother ill? If yes, please explain:

____

Please explain any notable episodes of mental or physical stress during your pregnancy:

____

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Please explain any other concerns or notable remarks about your child's conception or pregnancy:

____

Labor & Delivery History

Child birth was: Medicated vaginal birth Unmedicated vaginal birth

Scheduled cesarean Emergency cesarean

At how many weeks was your child born?

____

Child birth was: Hospital Birthing Center At home Other_____________________

Please check any applicable interventions or complications:

Breech Induction Pain Medication Epidural Episiotomy

Vacuum extraction Forceps Other____

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

____

Child's birth weight and height:____

APGAR Score (if known):____

Growth & Development History

Is/was your child breastfed? Yes No

If yes, how long?____

Any difficulty with breastfeeding?____

Did they ever use formula? Yes No

If yes, what age & what type:____

Did your child ever suffer from colic, reflux, or constipation as an infant? If yes, please explain:

____

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Did/does your child frequently arch their neck/back, feel stiff, or bend their head? If yes, please

explain:____

Please list any food intolerance or allergies, and whey they began:

____

Please list your child's hospitalization and surgical history, including the year:

____

Please list any major injuries, accidents, falls, and/or broken bones your child has sustained in his/her lifetime, including the year:

____

Has your child received any antibiotics? Yes No

If yes, how many times and list reason(s):____

How many hours of sleeping per night:____

Any night terrors or difficulty sleeping? Yes No

Behavioral, social or emotional issues? If yes, please explain:

____

How many hours per day does your child spend watching a TV, computer, tablet, phone, etc.?

____

How would you describe your child's diet? Mostly whole, organic foods

Pretty average High in processed/fast foods

Any other concerns? ____

PLEASE DO NOT SIGN UNTIL AFTER YOU MEET WITH THE CHIROPRACTOR.

I give my consent for the chiropractor to conduct a physical examination on my

child,________________________________. Date: _________________________________

Patient or Guardian Signature____

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