

Patient Information 1/9

Date: DD/MM/YYYY **Child's Name:** **Preferred Name:**
Sex: Male Female **Birthdate:** DD/MM/YYYY **Age:** **School Grade Level:**
Alberta Health Care #: **Street Address:**
Mother's Name: **Postal Code:** **City:** **Prov.:**
Father's Name: **Email:**
Home #: **Work #:** **Cell #:**
Emergency Contact: **Relationship:** **Phone #:**
** We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address? Yes No*

Medical Information 2/9

Family Medical Doctor's Name: **Clinic:**
Date of last MD visit: **Reason:**
Date of last physical examination:
What therapies has your child previously received? Chiropractic Massage Acupuncture Physiotherapy
** Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your child's medical doctor? Yes No*

Extended Health Benefits & Other Insurance 3/9

Do you have a private insurance plan? No Yes (Self) Yes (Spouse) Yes (Parent)
Name of primary policy holder (Spouse/Parent):
Policy #: **Which Company?** Alberta Blue Cross (ABC) SunLife
Member ID: **Group #:** (ABC Only) Great West Life Green Shield Standard Life
Is this a Workman's Compensation Case (WCB)? No Yes SSQ Financial Chamber of Commerce Desjardins
Date of Accident: Cowan Industrial Alliance Johnson
Is this a Motor Vehicle Accident Case (MVA)? No Yes Manulife Other:
Date of Accident:

How Did You Hear About Us? 4/9

Referred by Friend/Family Referred by Medical Doctor Internet/Website Street Sign
 Referred by Trainer Walk In Health Care Event Other:
**Whom may we thank for this referral?*

Current Health

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Primary Complaint/Purpose of Appointment:

When did this begin?

Has your child had this before? No Yes; **When:** **Is it getting:** Worse Better Not Changing

Is the Condition: Auto-Related Sports-Related Fall Other:

Has your child seen anyone else for this condition? No Yes; **Who:**

Has your child had any imaging for this condition: X-Ray CT MRI Ultrasound **Date:**

Is your child presently taking any medications/supplements?

Are there any secondary complaints/conditions?

Birth History

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Length of Pregnancy: Full Term (weeks): Early (weeks): Late (weeks):

Any issues during pregnancy for mom/baby?

Location of Delivery: Home Birthing Center Hospital

Type of Delivery/Interventions: Vaginal Cesarean Forceps Vacuum Breech Epidural

Length of Labor: Normal Difficult **APGAR Scores:** Jaundice

Birth Weight: **Birth Length:** **Congenital Anomalies:**

Infancy History

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Feeding: Breast Bottle Formula **Latching well:** Yes No **Breast Preference:** No Left Right

Sleep Quality: Good Fair Poor **Average Hours/Night:** **Average Hours in a Row:**

Trouble Falling Asleep: Always Occasional Never

General Health History

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Any Known Health Conditions/Illnesses? No Yes; **List:**

Childhood Diseases? Mumps Measles Chicken Pox Small Pox Diabetes Pneumonia Asthma

Big Falls or Injuries? No Yes; **List:** **Any Allergies?** No Yes; **List:**

Hospitalizations/Surgeries? No Yes; **List:**

Fractures? No Yes; **Where/When:**

Vaccination History:

Health Status Survey

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Please check the box of any conditions or symptoms that your child has had in the past six months:

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Eczema | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Hernias | <input type="checkbox"/> Sore Joints | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Feet Turn In/Out |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression/Confusion | <input type="checkbox"/> Colic | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Coordination Problems |
| <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Slow Weight Gain | <input type="checkbox"/> Neck Problems | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Seizures | <input type="checkbox"/> Pain b/w Shoulders | |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Spinal Curvature | |
| <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Arthritis | |