DR. MICHAEL CHAYE & DR. PAUL CHAUHAN
PATIENT INFORMATION (NEWBORN-14 YRS)

***Leave blank anything that you are unsure of the answer.**

Date: _____ Care Card#: _____

Child's Name: _____ Phone Number: _____

Address: _____ City:_____Postal Code:_____

Birth Date: _____ Sex: Male / Female (circle)

Names of Parents/ Guardians: _____

Emergency contact number of parent(s)_____

Name of Family Doctor: _____ Location_____

Previous Chiropractic Care? Y / N If yes, please indicate date of last visit: _____

Is this an ICBC claim (if yes please include claim no.)? _____

Referred by:_____

Purpose of visit? _____

(If wellness checkup continue to second page)

When did this problem begin? _____ Is this concern? (circle) occasional frequent constant intermittent

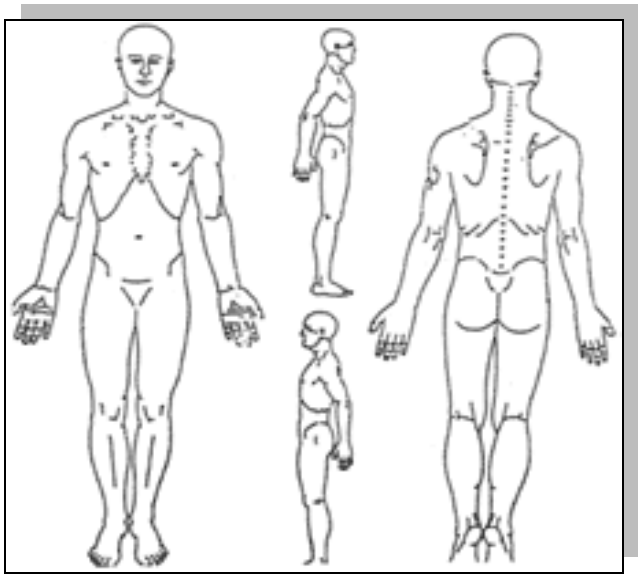
Does this problem travel to other parts of your body? Y / N If yes, where? _____

What makes this worse? _____ What makes this better? _____

Does this interfere with the child's sleep? Y / N eating? Y / N daily routine? Y / N

Is this problem becoming worse? Y / N If yes, explain: _____

Please circle any areas of pain or concern on the chart below:



Please check any of the following conditions your child has suffered from:

- ❑ Ear infections
- ❑ Asthma
- ❑ Allergies
- ❑ Colic
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Irritability
- ❑ Depression
- ❑ Loss of balance
- ❑ Loss of concentration
- ❑ Loss of memory
- ❑ Weakness
- ❑ Stiffness
- ❑ Chicken pox
- ❑ Scoliosis
- ❑ Bed wetting
- ❑ Digestive problems
- ❑ Seizures
- ❑ Ears buzzing
- ❑ Poor coordination
- ❑ Vision changes
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Light sensitivity
- ❑ Face flushed
- ❑ Cold sweats
- ❑ Muscle cramps
- ❑ Rubeola
- ❑ Whooping Cough
- ❑ ADHD
- ❑ Auto accident
- ❑ Chronic colds/coughs
- ❑ Temper tantrums
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Urinary problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Dental problems
- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Headaches
- ❑ Recurring fevers
- ❑ Growing pains
- ❑ Weight loss
- ❑ Weight gain
- ❑ Heart palpitations
- ❑ Chest pain
- ❑ Sinus congestion
- ❑ Sore throats
- ❑ Heartburn
- ❑ Back pain
- ❑ Sleeping problems
- ❑ Other _____

_____

Drug History

Number of prescription medications and antibiotics your child has taken:

a) Past six months: _____ b) During their life:_____

List (if you can recall): _____

Vaccinations:_____

Any negative reactions to vaccination? N / Y If yes, please list: _____

Prenatal History:

Complications during pregnancy? N / Y If yes, please list them: _____

Medications during pregnancy/ Delivery? N / Y If yes, please list them: _____

Cigarette/ alcohol use during pregnancy? N / Y Any smokers in the home? N / Y

Birth intervention: Forceps: _____ Vacuum Extraction: _____ Caesarian Section: _____ (emergency or planned)

Complications during delivery? N / Y If yes, please list them: _____

Genetic Disorders or Disabilities? N / Y If yes, please list them: _____

Developmental History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year life (i.e. bed, changing table, down stairs, etc.).

Was this the case with your child? N / Y

Is/Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? N / Y

Has your child ever been involved in a car accident? N / Y If yes, please list: _____

Has your child ever been seen on an emergency basis? N / Y If yes, please list: _____

Other traumas not listed above:_____

Prior surgery? N / Y, please list:_____

Do you feel that your child's social and emotional development is normal for their age? N / Y If no, explain:

_____

Other health problems, concerns/or anything we missed?

_____

As a result of chiropractic care, I would like my child to *(please check all that apply)*;

☐ Feel better quickly
☐ Have a healthier spine
☐ Have a healthier body by keeping their nervous system healthy
☐ Live a healthier lifestyle