



Infant and Child Patient Information (Infant to 12yrs old)

Date: _____ Health Care No: _____

Name: _____ Address: _____

Mother's Name: _____ Father's Name: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Parent's Business Phone: _____

Patient Birth Date: _____ Age: _____ Sex: M F

Number of Siblings: _____ Age of Siblings: _____

How did you find out about our centre? _____

HEALTH HISTORY

Major complaints: (Please list in order of severity)

1) _____ 3) _____
2) _____ 4) _____

No complaint. If your child is in for general evaluation (Skip Section A - go to Section B)

A

How long has the condition been present? _____ How did it occur? _____

Did the problem occur: immediately gradually

Did this ever happen before? Yes No

The problem: Comes and go Constant

The problem seems to be: getting better getting worse staying the same

List any medications being used: _____

What makes it better? _____ What makes it worse? _____

Have you seen another doctor about this problem? yes no. If yes, when? _____

Doctor's Name: _____ Treatment: _____

Have you tried home remedies? yes no If yes, explain _____

B

Were there any problems during pregnancy or childbirth? _____

Child's quality of sleep: a) good b) fair c) poor d) restless

Has your child had any broken bones? yes no Which bones? _____

Has your child experienced any dislocations? yes no Where? _____

Has your child been involved in a Motor Vehicle Accident? yes no

Are there heredity conditions in your family? yes no

Are you following an immunization program? yes no Any reaction to shots? yes no.

Below is a list of conditions which may seem unrelated to the purpose of your child's appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOUR CHILD HAS OR HAS HAD:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Small Pox | | | |

CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/ Bloating After Meals | GASTRO -INTESTINAL |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Black/Bloody Stool | <input type="checkbox"/> Poor/Excessive Appetite |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Frequent Nausea |
| <input type="checkbox"/> Joint Pain/Stiffness | | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Walking Problems | | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Difficulty Chewing/
Jaw Problems | GENITO -UNINARY CODE | <input type="checkbox"/> Constipation |
| | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Weight Trouble |
| | <input type="checkbox"/> Painful/Excessive Urination | <input type="checkbox"/> Abdominal Cramps or Pain |
| | <input type="checkbox"/> Discoloured Urine | |

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Weakness

C-V-R

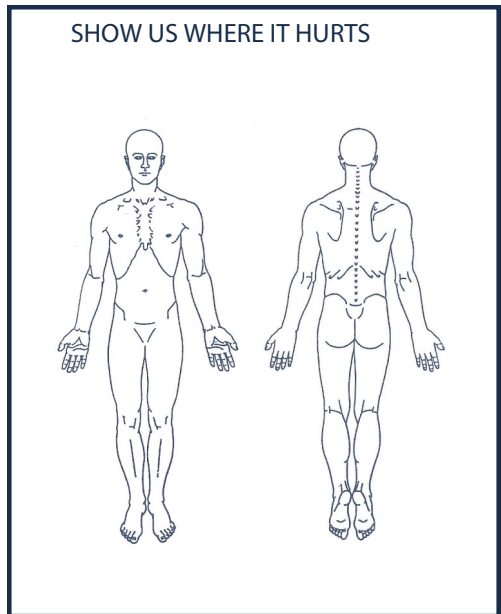
- Chest Pain
- Short Breath
- Lung Problems/Congestion

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Eye Infection
- Watery or Swollen Eyes

GENERAL CODE

- Allergies
- Loss of Sleep
- Fever
- Headaches
- Attention Deficit Disorder



Please list any other health problems you feel may be important:

Date _____

Patient Name _____