



DR. MARK GUKER

ReAlign Health Child Intake Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name _____ Date _____
Parent(s) Name _____
Siblings Names(Ages) _____
Address _____ City _____ Prov. _____
Postal Code _____ Home Phone(____) _____ Bus Phone(____) _____
Date of Birth _____ Age _____ Referred by _____

Has your child ever received chiropractic care? *Yes No*

If yes, previous DC's name and last visit date? _____

Name of Medical Doctor _____

Date of last MD visit and reason _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAMES _____ WORK TEL _____

I hereby authorize and consent to the chiropractic evaluation of my child.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major _____

Minor _____

When did this problem begin? _____

Is this problem (circle) *occasional frequent constant intermittent*

Does problem radiate? *Yes No* If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? *Yes No*

If Yes, when? _____

Does this interfere with the child's sleep? ___ eating? ___ daily routine? ___

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

FAMILY HEALTH HISTORY

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) **Yes No**

Please explain _____

Any evidence of birth trauma to the infant? (please tick)

- bruising*
- stuck in birth canal*
- respiratory depression*
- odd shaped head*
- fast or excessively long birth*
- cord around neck*

Any falls from couches, beds, change tables, etc? **Yes No**

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? **Yes No**

If yes, please explain _____

Any hospitalizations or surgeries? **Yes No**

If yes, please explain _____

Any sports played? _____

Is a school backpack used? **Yes No**

Is it heavy or light? (circle one)

CHEMICAL STRESSORS

Was this child breast-fed? **Yes No** If yes, how long? _____

Formula introduced at what age? _____ Which formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food/Juice intolerance? **Yes No** Type? _____

=====

During pregnancy, did the mother smoke? **Yes No** How much? _____

drink? **Yes No** How much? _____

Any illnesses during the pregnancy? **Yes No** _____

Any supplements taken during pregnancy? **Yes No** _____

Any drugs taken during pregnancy? *Yes No* _____

Any ultrasounds? *Yes No* How many and reasons for being done? _____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? *Yes No*
Please explain _____

Any pets at home? *Yes No* _____

Any smokers in the home? *Yes No*

Vaccination history Vaccinations and age given? _____

Any negative reactions? *Yes No* _____

Any antibiotics given? *Yes No* Reason _____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? *Yes No* _____

Any problems with bonding? *Yes No* _____

Any behavioural problems? *Yes No* _____

Any night terrors, sleep walking, difficulty sleeping? *Yes No* _____

Age of child when began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? *Yes No*

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.