Dr. Mark Guker
Dr. Phil Sammut
1-2445 Eagle St N
Cambridge, Ontario N3H 4R7
(519) 650-1630 www.realignhealth.com

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(____)_____
Email address: _____ (an email we can send apt reminders to)
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?_____

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Childs Name: _____

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?

_____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please tick if your child has had any of the following)

__ headaches
__ dizziness
__ fainting
__ fatigue
__ irritability
__ depression
__ loss of balance
__ loss of concentration
__ loss of memory
__ ears buzzing
__ poor coordination
__ vision changes
__ loss of smell
__ loss of taste
__ light sensitivity
__ face flushed
__ cold sweats
__ bronchitis
__ pneumonia
__ difficulty breathing
__ shortness of breath
__ asthma
__ urinary problems
__ constipation
__ diarrhea
__ weight loss
__ weight gain
__ dental problems
__ fevers
__ heart palpitations
__ chest pressure
__ breast pain
__ frequent colds
__ sinus congestion
__ sore throats
__ ear pain/infections
__ allergies
__ heartburn
__ bloating/gas
__ upper back pain
__ neck pain
__ low back pain
__ radiating pain
__ stiffness
__ reduced mobility
__ numbness in leg(s)
__ numbness in feet
__ numbness in hand(s)
__ weakness
__ muscle cramps
__ sleeping problems
__ other: _____

HISTORY OF BIRTH

What was the child's gestational age at birth? ____ weeks.

Birth weight _____lbs _____oz Birth length _____ inches

Was your child's birth at home, in a birthing center or in a hospital? (circle one)

Was the birth considered medical or midwife? (circle one)

What was the duration of the labour and birth? _____ hours

Was child born cephalic (head first) or breech (feet first)? (circle one)

Were there any complications? ***Yes*** ***No*** If Yes, please explain

_____
_____

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Childs Name: _____

Please circle any assitance which was used during the birth

Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***

Was labour spontaneous or induced? (circle one)

Were medications or epidurals given to the mother during birth? ***Yes*** ***No***
If yes, what was given

_____

APGAR score: at Birth ___/10 After 5 minutes___/10

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? Yes No
If no, please explain

_____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? Yes No
If no, please explain

_____

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.

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Childs Name: _____

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 ***__odd shaped head***
__stuck in birth canal ***__fast or excessively long birth***
__respiratory depression ***__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***

_____

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Childs Name: _____

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.