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Form for the new Little Ones

Date:

Before we begin, we would like to know to whom we owe an immense THANK YOU! For having referred you to us: _____

Please fill out all questions to the best of your knowledge, and send us the form back as soon as possible, in person, by fax or by email. Mom and/or Dad can help you. Everything will be reviewed with you later.
Thank you.

Personal Information

(*Please fill out with a pen*)

First name: _____ Last name:_____
Name of parent 1 / guardian: _____ Father's name: _____
Gender: ☐ F ☐ M ☐ Other
Date of birth: _____
Address: _____
City/Town/Municipality: _____
Postal Code:_____
Phone number Home: _____ Parent's work number:_____
Parent's cellular: _____
Mom or Dad's Email: _____
Can we send emails to this address? ☐ Yes ☐ No
In which way do you prefer to be reminded of your appointment?
☐ Phone ☐ Email
Quebec Health Insurance Number: _____ Exp _____
Do you have a pediatrician? If yes, what is his/her name? _____
What year are you in at school? _____
Which school do you go to? _____
What are the names of your brothers and sisters and their ages?
_____

Present history

Please tell us your story in your own words and pages if need be. If you are consulting us for wellness, tell us what else you are doing to support this goal. If you are consulting for a particular issue, tell us how you think this started, what has happened to you and what you have done since.

Have you consulted another specialist for the same reason that brings you here today?

- ☐ No
- ☐ Yes If yes, who? _____When? _____
  And how did it go? _____

Have you ever received chiropractic care?

- ☐ No
- ☐ Yes If yes, who was your chiropractor?_____
  Date of last adjustment: _____

What did you like best about the care? _____

What did you like least about the care? _____

Secondary objectives

Are there any other reasons for seeking care that you would like to have addressed eventually?

History

How long did your pregnancy last?
Did Mom take medicine and / or vitamins during pregnancy?
If yes, which ones? : _____

Were you born

☐ At home ☐ At a birthing center ☐ At the hospital, which one?_____

How long did your birth last, from the beginning of labor?_____

Were you a victim of birth trauma like

☐ Induction (provoked labor) ☐ Forceps or vacuum ☐ Other, specify:
☐ Peridural/epidural/anesthesia ☐ C-section

Were you separated from Mom at birth? ☐ Yes ☐ No
Did you receive vitamin K? ☐ Yes ☐ No
Erythromycin (antibiotic ointment in the eyes)? ☐ Yes ☐ No
Weight at birth: _____ Height at birth: _____
APGAR: _____
Present weight: _____ Present height: _____
Soon after birth did you have a jaundice? _____ a cyanosis (blue)?_____
Do you have one or many congenital anomalies? ☐ No
☐ Yes Which ones: _____
Were you breastfed (or are you still)?
☐ Yes If yes, how long were you breastfed? _____
Did it go well/is it going well with both breasts? _____
☐ No If no, what type of milk did you drink? _____

At what age did you start to:
Eat? _____ And what food did you eat first? _____
Walk on all fours? _____
Was it with hands and knees on the ground? _____
Walk on two feet? _____
Did you receive routine vaccination? ☐ Yes ☐ No
Did you suffer from adverse reactions to vaccines? ☐ No
☐ Yes If yes, describe briefly: _____

Have you ever…

Had surgery? ☐ No

☐ Yes If yes, when and why?_____

Been a victim of falls, car collisions or other trauma? ☐ No

☐ Yes If yes, when and describe briefly: _____

Broken any bones or lost consciousness? ☐ No

☐ Yes If yes, when and describe briefly: _____

Been hospitalized? ☐ No

☐ Yes If yes, when and why?_____

Family history

Are your father and mother in good health? ☐ Yes

☐ No If no, specify briefly:_____

If you have any, are your brothers and sisters in good health? ☐ Yes

☐ No If no, specify briefly:_____

Lifestyle

Do you take any medications (drugs)? ☐ No

☐ Yes If yes, which ones? _____

Since when and at what dosage?_____

Did you take antibiotics before the age of one?

☐ Yes ☐ No

Do you take supplements, including vitamins? ☐ No

☐ Yes If yes, which ones?_____

Since when and at what dosage? _____

Do you drink soft drinks? ☐ No

☐ Yes If yes, how many?_____

According to you, do you drink enough water? ☐ Yes ☐ No ☐ I do not know

How many glasses of water do you drink per day?_____

Do you exercise regularly? ☐ No

☐ Yes If yes, what do you do?_____

How many times per day or per week?_____

As a baby, were you put on your stomach and did you like it? _____

How many hours do you sleep per night? _____

Do you nap during the day? ☐ Yes ☐ No

Is your sleep good? _____

What position do you sleep in? _____

Do you sleep in your own bedroom? _____

Do you have a pillow?_____

Do you think you eat well? ☐ Yes ☐ No Are you vegetarian? _____

Do you eat fish, and if so, how often? _____

How many portions of cow's milk do you drink every day? _____

How many sweets, including dessert, do you eat every day? _____

Do you often eat…

☐ Meals prepared at home ☐ Restaurant meals

☐ Meals prepared in advance in a store or by a company?

Systems review

Do you suffer from difficulties with…

- ☐ Your eyes – recurrent infections, cross-eyed, near-sightedness, far-sightedness, etc.
- ☐ Your ears – ear infections, hearing difficulties, hearing constant sounds, etc.
- ☐ Your nose or sinuses – congestion, frequent colds, repetitive sinusitis, allergies, etc.
- ☐ Your mouth or your throat – abcesses, frequent sore throats, etc.
- ☐ Your digestion – colic, acid reflux, difficulty digesting certain foods, allergies, etc.
- ☐ Your elimination – frequent diarrhea/constipation, bedwetting, pain when peeing, etc.
    - How often do you have bowel movements?
    - Are you diaper-free day and night?
- ☐ Your lungs and your breathing – difficulty breathing, chronic bronchitis, asthma, etc.
- ☐ Your heart– heart problems, feeling of pressure over the chest, etc.
- ☐ Your nervous or vascular system – headaches, migraines, dizziness, fainting, tremors (shaking), numbness, memory loss, etc.
- ☐ Your skin – frequent irritations, unusual pimples/plaques, psoriasis, eczema, rashes, etc.
- ☐ Your osseous and articular system – joint pains, growing pains, etc.
- ☐ Your emotional and psychological health – towards home, school, your friends, the death of a loved one, irritability, fatigue, nervousness, hyperactivity, etc.

Expectations

What are your expectations by coming here?

Do you wish to receive care…

- ☐ Symptomatic care to reduce pain
- ☐ To restore your health ❒ To maintain your health
- ☐ To increase your level of well-being (better-being)

Health and Quality of life are among the most precious things in this world – YOUR HEALTH AND YOUR FAMILY'S HEALTH. Chiropractic is there for You. The adjustments will help you to express your full potential of life. When you receive a chiropractic adjustment, the work has just begun. During the hours and days that follow your adjustment, your Innate Intelligence will continue to work by using the information received during the adjustment in order to make you better and help you. At the Maison Chiropratique Petits et Grands, we adjust people and the body decides, with its Innate Intelligence, what needs to be done, and what can still be done. Hence, we work in harmony with your inner wisdom. However, this process implies that you take back control of life and of your health, and that you accept to invest yourself in assisting "Dr You".

I recognize that the given information is exact to the best of my knowledge and I consent to receive any necessary examinations.

Signature of parent **Date**