STONEBRIDGE CHIROPRACTIC

Today's Date: _____

INFANTS/ CHILDREN CASE HISTORY

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Mother's Name: _____ Father's Name: _____
Home Phone#: _____Cell Phone #: _____
Email: _____Saskatchewan Health Card #_____
How do you want appointment reminders sent to you? Circle one: Email / Text message / Not at all

Birth Date (mm/dd/yy):_____ Age:_____ Sex:_____

Who referred you to our office?_____

What is your reason for consulting our clinic? General spine exam? _____
_____

What was the length of the delivery? Caesarian section? Vaginal birth? Forceps? _____

Were there any complications during the pregnancy or labour? _____
_____
_____

What was the child's birth weight? _____ Length? _____ Current weight? _____
The Apgar score at birth_____/_____

Duration or pregnancy? _____weeks
-or- was birth within two weeks of due date, early (how much) _____or late (how much) _____

Does he/she tend to favor one side when nursing? _____

Has the child ever had any food allergies? Sensitivities? _____

How many bowel movements per day? Any obvious discomfort with bowel movements? _____
_____

How many wet diapers per day? _____ Is your child gassy? _____ Are they difficult to burp? _____

NUTRITION

- ☐ Breast milk
- ☐ Formula
- ☐ Cow's milk
- ☐ Soy milk
- ☐ Juice: Fruit
- ☐ Vitamins/Supplements
- ☐ Other_____
  _____
- ☐ Solid foods - If yes, when were they started and what was first introduced? _____
- ☐ Medications - please list: _____

Please check any area that applied to the patient's Mother during pregnancy:

- ☐ Tobacco
- ☐ Vitamins/Minerals
- ☐ Recreational drugs
- ☐ Alcohol
- ☐ Hospitalization
- ☐ Immunization
- ☐ Bleeding
- ☐ High blood pressure
- ☐ Back pain
- ☐ Premature contractions
- ☐ Prenatal Massage
- ☐ Chiropractic care
- ☐ Prenatal classes
- ☐ Prenatal care
- ☐ Carried to full term

Excessive decrease in weight _____ How much? _____
Excessive increase in weight _____ How much? _____
Medications (please list) _____

LABOR and DELIVERY

Hospital or birthing home (Name) _____ Home Birth Y N

- ☐ Medications
- ☐ Were forceps or suctions used
- ☐ Cesarean
- ☐ Back labour

- ☐ Fetal monitor used If yes, internal or external (circle one or both)
- ☐ Premature delivery If yes, how many weeks _____
- ☐ Late term delivery If yes, how many weeks _____

Please list any complications _____
Other: _____ Please explain: _____

Please check if any items apply to the patient at birth:

- ☐ Medication
- ☐ Surgeries
- ☐ Artificial feeding
- ☐ Silver nitrate
- ☐ Vitamin K

Please check if any problems the patient had soon after birth:

- ☐ Breathing
- ☐ Colouring
- ☐ Crying
- ☐ Choking
- ☐ Nursing
- ☐ Sleeping
- ☐ Jaundice

Has your child been involved in any motor vehicle accidents? Y N
Injuries? Treatment?_____
Has your child experienced any major falls?_____
Has your child experienced any major childhood infections?_____
Have they taken any prescription medications or antibiotics?_____
Does your child exhibit any difficulty with movement of head or body awkwardness?_____
Has your child begun crawling? Walking? At what age? _____
Are they very physically active? _____

Has your child experienced any of the following?

- ☐ Asthma
- ☐ Allergies
- ☐ Skin rashes
- ☐ Frequent fevers
- ☐ Sinus infections
- ☐ Ear infections (R or L)
- ☐ Vomiting
- ☐ Excessive abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty hearing
- ☐ Bed wetting
- ☐ Colic
- ☐ Seizures
- ☐ Unexplained crying
- ☐ Other: Explain _____

Please list any conditions or illnesses that have already been diagnosed. Including and serious mental or physical traumas for which treatment was recommended and/or received. _____

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients, Chiropractors and other therapists, I understand that I must give **3 hours' notice** if I cannot make it to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, FHB, WCB and other insurances do not cover the cost of a missed appointment. Please help us serve you better by keeping scheduled appointments.

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies in regards to provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance.

I have read, understood and agree to the above financial policies.

Patient Signature: _____Date: _____