

Infant, Child & Adolescent Health History Intake Form

Last Name: _____ Given Name: _____

Birthdate (D/M/Y): _____ Gender: F M

Parent 1: _____ Parent 2: _____

Address: _____ Apt. No. _____

City: _____ Province: _____ Postal Code: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

E-mail (for appointment reminders and health newsletters only): _____

TELL US ABOUT YOUR PREGNANCY:

Did you carry to full term? _____

Describe any complications and when they occurred:

TELL US ABOUT YOUR DELIVERY AND BIRTH OF THIS CHILD:

Did you use a midwife?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Were you induced?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hospital?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Did you have an Epidural?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Obstetrician?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Was it a difficult birth?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Did you have a C-Section?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Baby's APGAR Score at birth?	_____	
Were forceps used?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Baby's APGAR Score at 5 minutes?	_____	
Vacuum Extraction?	<input type="checkbox"/> Y	<input type="checkbox"/> N			

TELL US MORE:

Did you breastfeed? Y N How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? Y N How much? _____

Did you smoke? Y N How much? _____ How long? _____

Did you take any medication during your pregnancy? Y N For what? _____

What type(s)? _____

Any exposures to ultrasound? Y N How many? _____



Annex Family
CHIROPRACTIC
EMPOWERING YOU FOR OPTIMAL HEALTH

Dr. Joshua Gelber, D.C.
Principled Wellness Chiropractor

416 967 4466 • annexfamilychiropractic.com
206-738 Spadina Ave, Toronto, ON M5S 2J8

Health Profile

AS A BABY/TODDLER, (BIRTH TO 4 YEARS), DID ANY OF THE FOLLOWING OCCUR?

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Constipation | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Play in A Jolly Jumper @ _____ mos/yrs | <input type="checkbox"/> Reaction to vaccination |
| <input type="checkbox"/> Frequent bouts of diarrhea | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Other: _____ |

AS A YOUNG CHILD, (5-12 YEARS), HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Stomach pains |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Sports accident | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Fall of a bicycle | <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hyperactivity/Autism | <input type="checkbox"/> Car accident | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fall of playground equipment | <input type="checkbox"/> Allergies | |

AS A CHILD OR ADOLESCENT, HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Foot/ankle/knee pains | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck/back pains | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Frequent bouts of diarrhea | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> Tingling in arms/legs | <input type="checkbox"/> Shoulder pains | |

Which of the problems you have checked off is the worst? _____

Is this problem: Constant Intermittent Occasional Cyclic

How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

What have you done about it that has not worked? _____

What makes it worse? _____

What effect does this problem have on your child's body functions? _____

On his/her participation in daily activities? _____

Describe any hospital stays: _____

Approximately how many times have antibiotics been prescribed and for what conditions? _____

List any medications your child is currently taking: _____

To summarize, what is your purpose for this appointment? _____

Is there anything else you feel we should know? _____

Signature of Parent or Guardian: _____

Date: _____



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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Annex Family Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation (Nervous System Traffic Jam): A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our only practice objective is to eliminate a major interference to the expression of the body's internal power. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept the potential for chiropractic care on this basis.

Patient Signature/Guardian's Consent

Date