chiro st-martin

PEDIATRIC CONSULTATION FORM (0-6 years)

Thank you for your trust!

1. INFORMATION

Full name _____

Date of birth (*dd-mm-yy*) _____

Age _____

Address _____

City _____

Postal code _____

Cell Phone _____

Home Phone _____

Email _____

Confirmation by : ○ email ○ phone

Parent's name

_____

_____

Is your treatment covered by insurance?
○ No ○ Yes

Are you referred by :
○ website ○ health professional : _____
○ patient, name : _____

Weight _____ Height _____

2. REASON OF CONSULTATION

Describe all the problem of your child or baby :

_____

_____

_____

Cause (accident, birth, etc.) :

_____

_____

When did it start : _____

How many days a week does this problem affect the baby? _____

When is the problem worse?
○ morning ○ evening ○ night ○ constant

What does increase the problem?

_____

_____

What does relieve the baby?

_____

_____

Are there other symptoms?
○ No ○ Yes, which ones : _____

_____

Have you consulted anyone else for your baby?
○ No ○ Yes
Who? _____
When? _____

Have you done other tests (e.g. blood test, scan, etc.) for the condition?
○ No ○ Yes
Which one? _____
When? _____

Have you ever consulted a chiropractor for your baby?
○ No ○ Yes, last visit : _____

3. DURING PREGNANCY AND BIRTH

Number of weeks of pregnancy at birth : _____

Did you suffer from :
○ pre-eclampsia
○ gestationnal diabetes
○ bleedings
○ others difficulties : _____

Did you give birth :
○ vaginal
○ c-section
○ with epidural
○ with antibiotics
○ with induction

Complication at birth :
○ forceps
○ vacuum
○ episiotomy
○ collarbone fracture
○ jaundice

How long was :
labour (latent and active labour) _____
pushing _____

Apgar score _____
Weight at birth _____
Height at birth _____

4. FEEDING AND BABY'S DEVELOPMENT

Baby feed :
○ Formula
○ Breastfeeding, number of months : _____

Did you have difficulty with breastfeeding?
○ No ○ Yes, specify : _____

_____

Is your baby/child :
○ have a head preference
○ have a flat head, specify : _____
○ toe walking
○ walk with the foot turned inward or outward

Baby had :
○ colic
○ reflux
○ regurgitation
○ constipation
○ diarrhea
○ food allergy
○ otitis

Specify : _____

_____

5. NEUROVERTEBRAL DISORDERS

Among these neurovertebral disorders did your child ever have (if yes, specify when and describe) :

Car accident : ○ No ○ Yes

_____

Accidental fall : ○ No ○ Yes

_____

Important trauma : ○ No ○ Yes

_____

6. LIFESTYLE HABITS

What is the sleep position of your child?
○ back ○ side left/right ○ stomach

The diet of your child is :
○ healthy ○ medium ○ bad

Your child consume :
○ red meat
○ dairy products
○ sugar
○ juice

7. HEALTH PROBLEMS SECTION

Have your child been hospitalized or had surgery?
○ No ○ Yes, specify :

_____

_____

Indicate health problems.

_____

_____

Did your child consume antibiotics :
○ No ○ Yes, specify : _____

_____

Indicate any medication (prescription or OTC) or natural products :

_____

Indicate your family history health problems :
Mother _____ Father _____
Brother/sister _____

Is your child suffering :

GENERAL
○ Night swells
○ Fatigue
○ Anxiety
○ Cancer
○ Loss of appetite
○ Fever
○ Weight Gain
○ Unexplained weight loss

NEUROLOGICAL
○ Dizziness
○ Headaches
○ Migraines
○ Weakness
○ Tremors

MUSCULOSKELETAL
○ Arthritis
○ Neck pain
○ Back pain
○ Scoliosis

RESPIRATORY
○ Asthma
○ Cough
○ Respiratory problem

ENT
○ Vision trouble
○ Otitis
○ Loss of hearing
○ Nosebleeds

OTHER
○ Anemia
○ Ulcers
○ Arrythmia
○ Incontinence

I declare that all information provided is complete and accurate. I consent to the examination.

Parent's signature _____ Date _____