Hunter Chiropractic Wellness Centre **Child Admittance Form**

Name:________________________ Gender: ☐ M ☐ F	Home Phone:________________
How would prefer to be addressed?____________________	Cell Phone: ________________
Street: Address: ________________________________	Guardian's Name: ____________
City:______________Prov:______Postal Code__________	Relationship:________________
Birth date: Month: _______ Day: _______ Year: _______ Age: ______	Guardian's Phone #____________
Email:____	Insurance Company:____________
School grade level: ______________________________	Coverage Amount: $ __________ per year

How did you hear about our office: ____

Reason for appointment: ☐ I have no complaints, I am here for a wellness check-up ☐ I have a specific concern

Indicate your <u>primary condition</u> (if applicable):____

Is your condition due to an accident? ☐ No ☐ Yes Type of Accident: ☐ Auto ☐ Work ☐ Other

When did your condition begin?____________________ **Have you had this condition before?** ☐ No ☐ Yes

What caused your condition?____

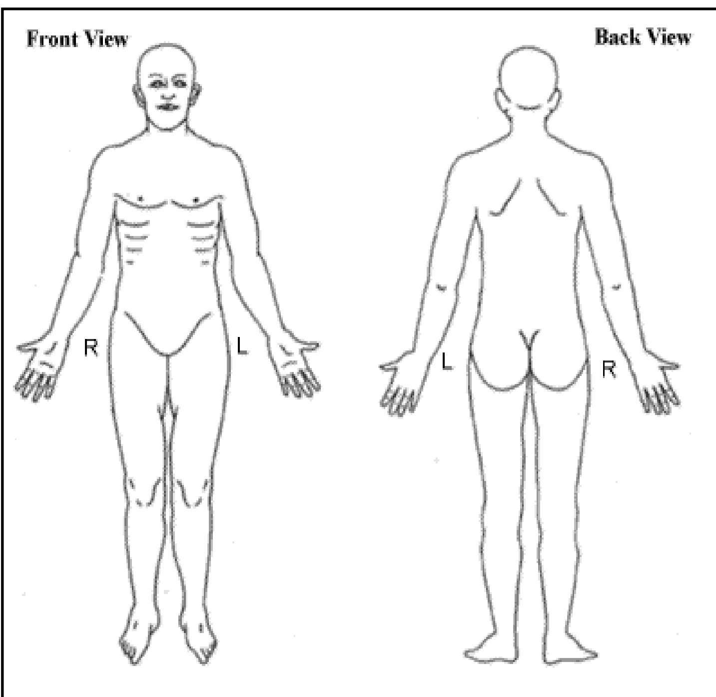
Have you had previous treatment for this condition? ☐ No ☐ Yes If so, specify what and when:

____

Have you had X-rays, MRI, or other tests <u>for this condition</u>? ☐ No ☐ Yes If so, specify what and when:

____

Does this condition interfere with your: ☐ work ☐ sleep ☐ personal life ☐ mood ☐ activities ☐ other



Rate the intensity of your condition (please circle):

(least) 1 2 3 4 5 6 7 8 9 10 (worst)

Is your condition: ☐ **Constant; or** ☐ **Occasional**

What aggravates your condition?

____

What relieves your condition?

____

Indicate on the diagram to the left:

- **S** - for Sharp pain
- **D** - for Dull pain / ache
- **T** - for Tingling/ numbness
- **B** - for Burning / throbbing

HEALTH HISTORY

Circle "C" for conditions you are currently experiencing or "P" for conditions you have had in the past.

Unexplained weight loss	C | P	Slurred speech	C | P	Poor concentration or memory	C | P	Headaches	C | P
Unrelenting pain (day and night)	C | P	Previous stroke	C | P	Frequent colds/infections	C | P	Jaw pain	C | P
Loss of bowel/bladder function	C | P	Blurry/double vision	C | P	Anxiety/depression	C | P	Neck pain	C | P
Fever/Chills/Sweats	C | P	Heart palpitations	C | P	Stomach pain	C | P	Mid-back pain	C | P
Poor appetite	C | P	Fainting or dizziness	C | P	Constipation/diarrhea	C | P	Shoulder pain	C | P
Pain over heart	C | P	Ringing in ears	C | P	Heartburn	C | P	Elbow pain	C | P
Spitting up blood/phlegm	C | P	High/Low blood pressure	C | P	Poor digestion	C | P	Wrist/hand pain	C | P
Difficulty swallowing	C | P	Difficulty sleeping	C | P	Varicose veins	C | P	Low back pain	C | P
Nausea/vomiting	C | P	Tremors	C | P	Cold/swollen hands or feet	C | P	Hip pain	C | P
Blood in stool/urine	C | P	Chronic cough	C | P	Ear infections	C | P	Ankle/Foot pain	C | P
Difficulty breathing	C | P	Painful urination	C | P	Painful/irregular cycles	C | P	Numbness/Tingling	C | P

Indicate any secondary conditions concerning you:____

____

Indicate all other health diagnoses given: ____

Check ✓all repetitive stressors you are currently experiencing:

Prolonged sitting	☐	Desk / computer work	☐	Repetitive lifting	☐	Emotional stress	☐
Prolonged standing	☐	Poor posture	☐	Repetitive sports/hobbies	☐	Lack of sleep	☐

Other repetitive stressors:____

Have you had previous chiropractic care? ☐ No ☐ Yes

If so, Dr.______________________ Clinic Name:______________________________ Date:________________

List all medications and supplements you are currently taking:______________________________

____

List all previous surgeries, illnesses, accidents and injuries:______________________________

____

Other relevant health information:____

____

Teenage Females: Are you pregnant? ☐ No ☐ Yes ☐ Not Sure If yes: Due Date: ________________________

Patient's signature: ____

Parent/Legal Guardian's signature: ______________________________ Date: _________________