Hunter Chiropractic Wellness Centre

Child Admittance Form

Name:_____ Gender: ☐ M ☐ F	Home Phone:_____
Address: _____	Cell Phone: _____
City:_____Prov:_____Postal Code_____	Guardian's Name: _____
Birth date: Month: _____ Day: _____ Year: _____ Age: _____	Relationship:_____
Email:_____	Guardian's Phone #_____
School grade level: _____	Insurance Company:_____
	Coverage Amount: $ _____ per year

How did you hear about our office: _____

Have you had previous chiropractic care? ☐ No ☐ Yes If yes, approx. how long ago: _____

Indicate your primary symptom: _____

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

When did your symptom begin?_____ **Have you had this symptom before?** ☐ No ☐ Yes

What do you think caused your symptom?_____

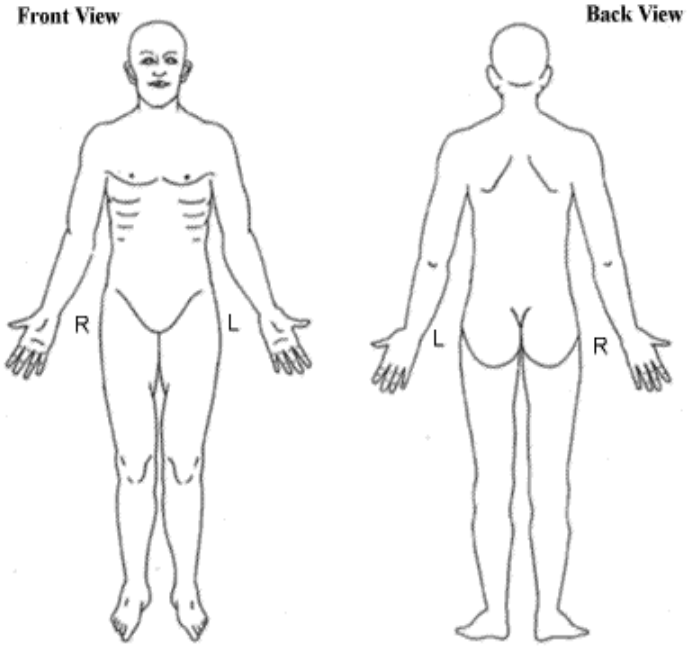
Have you had previous treatment for this symptom? ☐ No ☐ Yes If so, specify what and when:

_____

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

_____

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



Rate the intensity of your symptom (please circle):

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

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

What aggravates your symptom?

_____

What relieves your symptom?

_____

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:_____

_____

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: _____

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