FOCUS
CHIROPRACTIC CENTRE

PEDIATRIC PATIENT APPLICATION

Welcome to our office!

At Focus Chiropractic, we are passionate about assisting our patients and their families to achieve their highest level of health through advanced spinal corrective programs and lifestyle improvements. Our practice is unique and utilizes the 5 Essentials protocol to maximized health, which allows our patients to achieve superior results in life.

Patients from around the world call us their healthcare team. We take your health very seriously. We are a local office with a global reach.

Please fill out the following information **as thoroughly as possible** so our Doctors can let you know if yours is a case we can accept. If you have any questions or need assistance, feel free to ask our team. We look forward to serving you.

_____
Patient Name *(please print)*

_____
Parent/Guardian Signature

_____
Today's Date

Office Use Only

Referral _____
Walk In
MPI/WCB: Claim #_____ Date of Accident: _____

6 View
Cervical
Thoracic
Lumbar
Other

DOB _____

ID _____

Assignment _____ DR _____

FOCUS CHIROPRACTIC

PEDIATRIC APPLICATION SURVEY

Childs Name _____ Gender M F Age _____

Home Address _____ Home Phone _____

City, Province, Postal Code _____ Manitoba Health (6 digit) _____

Birth Date (MM/DD/YY) _____ / _____ / _____ Manitoba Health (9 digit) _____

Birth Height _____ Birth Weight _____ Current Height _____ Current Weight _____

Mother's Name _____ Mother's Cell _____

Father's Name _____ Father's Cell _____

Pediatrician/Family MD _____ Last Visit, reason _____

PURPOSE OF THIS VISIT

_____Wellness Check-up _____Injury or Accident _____Other Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long*** _____

_____

When did the Problem first begin? Date ____/____/_____ , Did it begin: ___Gradually ___Suddenly ___Progressive over time

Has your child experienced this problem before? ___No ___Yes; If yes when? _____

Any bowel or bladder problems since this problem began?: ___No ___Yes; If yes, describe: _____

Have you seen any other doctors for this problem? ___No ___Yes; If yes who? _____

How long ago? _____Days _____ Weeks _____ Months _____Years

What were the results of past treatment? _____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any **medication taken** for this problem: _____

Has your child ever sustained an injury playing organized sports? ___No ___Yes; If yes; please explain _____

Has your child ever sustained an injury in an auto accident? ___No ___Yes; if yes, please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: *check all that apply*

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□ Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Allergies to_____
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Asthma
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Colic	□ Broken Bones	□ Sleeping Problems
□ Fall in baby walker	□ Fall from bed or couch	□ Fall from crib	□ Fall off swing
□ Fall off bicycle	□ Fall from high chair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off monkey bars	□ Fall off skateboard/skates	□ Other: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy? ___No ___Yes; If yes, please explain _____

Ultrasounds during pregnancy? ___No ___Yes; If yes, how many? _____

Medications during pregnancy/delivery? ___No ___Yes; If yes, what? _____

Cigarette/alcohol use during pregnancy? ___No ___Yes

Location of birth: _____ Hospital _____ Birthing Centre _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section, emergency or planned

Complications during delivery? ___No ___Yes; If yes, please explain _____

Genetic disorders or disabilities? ___No ___Yes; If yes, please explain _____

INFANCY HISTORY

Number of doses of Antibiotics your child has taken: During the past 6 months: _____ Total during his/her lifetime: _____

Number of doses of Prescription medications your child has taken: During the past 6 months: ___ Total during his/her lifetime: ____
List: _____

Vaccination History: _____

Feeding History

Breast Fed: ___No ___Yes; If yes how long? _____

Formula Fed: ___No ___Yes; If yes how long and type? _____

Introduced to solids at _____ months, introduced to cow's milk at _____ months

Food/juice allergies or intolerances: ___No ___Yes; If yes please list _____

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic and Rehab facility we have on main goal to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 is by specific adjustments of the spine.

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

Vertebral Subluxation: 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.