FILE OPENING AND PEDIATRIC ADMISSION

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Patient identification

Last name :_____ First name :_____ Sex : ☐ M ☐ F

Date of birth : _____ Age : _____ Corrected age (premature) : _____

Address : _____ City : _____ Zip code : _____

Referred by : _____

Family information

Parent's name : _____ Parent's name : _____

Phone # (home) : _____ Phone # (home) : _____

Phone # (cellphone) : _____ Phone # (cellphone) : _____

Phone # (work) : _____ Phone # (work) : _____

Email : _____ Email : _____

Occupation : _____ Occupation : _____

Which way is best to reach you? ☐ phone (home) ☐ phone (cell) ☐ phone (work) ☐ email

Authorization to contact you by email (appointment confirmation, insurance reciepts, etc)? ☐ Yes ☐ No

Authorization to leave a message at the specified phone number, to confirm appointments? ☐ Yes ☐ No

Holder of parental authority : ☐ Two-parents ☐ Single parent ☐ Shared custody

Siblings Ages : _____ Known health issues : _____

Reason(s) for consultation : ☐ Prevention ☐ For a specific problem

Main reason : _____

Present since when? _____ How did it happen? _____

Other problems : _____

Pregnancy history :

Health issues during pregnancy (by trimester) : _____

Exams and tests : _____

Position of baby (last trimester) : ☐ Head down ☐ Breech ☐ Other / don't remember

Prescribed medication : _____ Reason : _____

Over the counter medication(s) : _____ Reason : _____

Natural products and vitamins : _____

☐ smoking ____/day ☐ Alchool ____/week ☐ Drugs ____/week

☐ Fall ☐ Accidents ☐ Hospitalization (reason) : _____

☐ Other : _____

Delivery and childbirth :

Lentght of labor (regular contractions to birth) : _____ hours Lenght of pushing : _____ hours / min.

Place of birth : ☐ Hospital ☐ Birthing home ☐ At home ☐ Transfer ☐ Other : _____

Vaginal : Presentation ☐ Head ☐ Face ☐ Breech ☐ Posterior (nose upwards) ☐ VBAC ☐ Other : _____

Cesarean : ☐ Planned ☐ Not planned _____

Medication : ☐ Epidural ☐ Pitocin ☐ Other : _____

Interventions : ☐ Vacuum ☐ Forceps ☐ Episiotomy ☐ Aspiration ☐ Rescucitation ☐ Other : _____

☐ Shoulder dystocia ☐ Bump on the head ☐ Marks (head, face, body), where? _____

☐ Clavicle fracture ☐ Other : _____

NICU / hospitalization Lenght : _____ Reason : _____

Health history :

Dr.'s name : _____ Other professionals seen : _____

Dates and reasons for consultations : _____ Dates of consultations : _____

Health issues since birth : _____ Medications : _____

Health issues in the family : _____ Surgery : _____

Accidents or falls : _____

At what age did your child do? (answer what applies)

Hold his head : _____ Moving any other way than crawling, specify : _____

Sitting alone : _____ Stand-up : _____

Crawl : _____ Walk alone : _____

Crawl hands & knees : _____ Stumbles or falls often? _____

Consent :

Accuracy of information

☐ I hereby declare the information provided about my child, is to my knowledge, accurate and complete

Consent to the exam

☐ I hereby authorize the chiropractor to perform the examinations he deems necessary to open my child's file.
It is possible that some patients may experience discomfort or a slight worsening of symptoms following the examination. These symptoms are usually short-lived, but it is important to mention them to the chiropractor at your next visit.

_____	_____	_____
Parent's name (block letters)	**Signature**	**Date**