Chiro-Santé Kirkland Clinic

Opening File (Pediatric)

Child's Name: _____ Child's Gender: _____ Date of Birth: _____

Mother's Name: _____ # of Brothers: _____ # of Sisters: _____ Rank: _____

Father's Name: _____ Who recommended our clinic to you? Friend: ❑ Family: ❑ Internet: ❑

Address: _____ Other: ❑ _____

Province: _____ Postal Code: _____ Who recommended us? _____

E-mail address: _____

Home Phone: _____ Cell Phone: _____

BIRTH AND DELIVERY:

Weight at Birth: _____ Current Weight: _____

Height at Birth: _____ Current Height: _____

Difficulties during pregnancy: _____

_____

_____

Delivery Type: Normal Vaginal: ❑ Forceps: ❑ Breech: ❑ Cesarean: ❑

At Home: ❑ In Hospital: ❑ Hospital Name: _____

Difficulties during delivery: _____

Length of labor: _____ APGAR Score : _____

At Birth was there: Jaundice: ❑ Cyanoses (blue): ❑ Congenital abnormalities: ❑

Feeding: Breast: ❑_How Long: _____ Bottle: ❑_Type of Milk: _____

Sleeping: ____ Hours per night; His sleeping is good: ❑ Fair: ❑ Agitated: ❑

Child's Pediatrician: _____

Date of last visit: _____ Reason: _____

Diagnosis (if any): _____

Vaccination History: _____

_____

_____

Childhood Diseases: _____

_____

_____

Other: _____

_____

_____

REASON FOR CONSULTATION:

_____

_____

_____

_____

_____

DECLARATION FOR ALL:

I hereby declare that the information provided herein is accurate and complete. I consent to any neccessary examinations for my child.

Date: _____ Signature: _____