



CHILD HISTORY FORM

Date: _____

Dear New Practice Member: It is a pleasure to welcome you to Balance Family Chiropractic. To help us serve you better, please complete the following information. We look forward to working with you to build better health for you and your family.

Practice Member Name: _____
Address: _____ City: _____ Province _____
Postal Code: _____ Home Phone: _____
Birth Date (day/month/year) ___/___/___
E-mail _____
Who Referred You? _____
Names of Parents/Guardians _____

Purpose For Contacting Us? _____

Please circle any of the following conditions you have suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds
Asthma	Digestive Problems	ADHD	Recurring Fevers
Allergies	Bed Wetting	Car Accident	Headaches
Autism	Growing Pains	Back Pain	Other

Does condition interfere with:

Sleeping? yes no Daily Activities? yes no Exercising? yes no

When did you first notice this condition? _____

Were you ever knocked unconscious? Yes No Comments: _____

Have you ever broken any bones? Yes No Comments: _____

Previous Chiropractic Experience? Yes No Name of Chiropractor: _____

Date of last visit: ___/___/___

Name of Family Doctor: _____ Date of last visit: ___/___/___

Reason: _____

Number of Doses of Antibiotics taken: During the past six months: _____

Total during lifetime: _____

Number of Doses and type of Other Prescription Medications taken:

During the past six months: _____

Total during lifetime: _____

Vaccination History: _____

Are you involved in any high impact or contact sports (ie. Soccer, Football, Gymnastics, Baseball, Ballet, Martial Arts, etc) Yes No List:

Have you ever been involved in a car accident? No Yes List: _____

Have you ever been seen on an emergency basis? No Yes List: _____

Have you ever been hospitalized? No Yes List: _____

What was actually done to you? _____

Other traumas (falls, accidents, injuries) not described above? No Yes List: _____

Prior Surgery? No Yes List: _____

Birth History

Complications during pregnancy? No Yes List: _____

Medications during pregnancy/delivery? No Yes List: _____

Birth Intervention: Forceps ___ Vacuum Extraction ___ Ceasarian Section ___
Emergency/Planned___

Complications During Delivery? No Yes List: _____

Genetic Disorders or Disabilities? No Yes List: _____

Have you had: a spinal tap___ spinal injections___ physiotherapy___
Neck collar___ spinal brace___ heel lift___ corrective shoes ___ chemotherapy___
transfusion___ bone in a case or immobilized___ naturopathy___ homeopathy___

Have you ever had X-rays done before? No Yes When? _____

I hereby authorize Dr. Jennifer Murray or her designate to examine my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by Murray-Morton Family Chiropractic.

Signed: _____ Witnessed: _____ Date: _____
____/____/____