FOCUS FAMILY
chiropractic

Child Admittance Form

Last Name:	First Name:	Preferred Name:	
Address:			
City:	Province:	Postal Code:	
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )	
Alberta Health Care #		Gender: M / F	
Emergency Contact Name:		Emergency Contact Phone ( )	
Date of Birth:	Age:	Height:	Weight:
Guardian/ Parent names:			
Email address:		(Email will be used for appointment reminders, receipts, communications, etc.)	
Did anyone refer you?			

Please check all answers and fill in the blanks where appropriate.

Reason(s) for appointment: _____

Describe your primary complaint if applicable: _____

When did your condition begin? _____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when? _____

_____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur? _____

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

Circle the intensity of your symptoms: (least intense) 1 2 3 4 5 6 7 8 9 10 (most intense)

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date: _____

Please check all the conditions/ illness you have experienced or been diagnosed with:

3 Months	Over 1yr.		3 Months	Over 1yr.		3 Months	Over 1yr.	
☐	☐	Neck pain	☐	☐	Mid back/ shoulder blade pain	☐	☐	Low back pain
☐	☐	Headaches/ migraines	☐	☐	Asthma/ wheezing	☐	☐	Numbness in legs/feet
☐	☐	TMJ	☐	☐	Pain with deep breathing	☐	☐	Frequent/ difficulty urinating/ blood in urine
☐	☐	Hearing disturbances	☐	☐	Nausea	☐	☐	Diarrhea
☐	☐	Thyroid conditions	☐	☐	Indigestion/ heartburn/reflux	☐	☐	Constipation
☐	☐	Numbness in arms/hands	☐	☐	Spitting up phlegm/ blood	☐	☐	Blood in stools
☐	☐	Recurrent cold/flu/hands	☐	☐	Tired/ irritable	☐	☐	Muscle cramps in legs/feet
☐	☐	Dizziness/ fainting	☐	☐	Recurrent lung infections	☐	☐	Injury in hip/knee/ankle
☐	☐	Allergies/ Hay fever	☐	☐	Shortness of breath	☐	☐	Pain into hips/legs/feet
☐	☐	Tingling in arms/ hands	☐	☐	Heart attacks/ angina	☐	☐	Coldness in legs/feet
☐	☐	Weakness in grip	☐	☐	Hardening of arteries	☐	☐	Recurrent bladder infections
☐	☐	Visual disturbances	☐	☐	Rapid heartbeat	☐	☐	Tingling in legs/feet
☐	☐	Low energy/ fatigue	☐	☐	Slow heartbeat	☐	☐	Weak in legs/feet
☐	☐	Loss of consciousness	☐	☐	High blood pressure	☐	☐	Swelling in ankles
☐	☐	Whiplash injury	☐	☐	Low blood pressure	☐	☐	Sciatica
☐	☐	Convulsions	☐	☐	Heart or blood diseases	☐	☐	Arthritis
☐	☐	Speech problems	☐	☐	Pain in chest/ribs	☐	☐	Loss of sleep
☐	☐	Difficulty swallowing	☐	☐	Hypoglycemia	☐	☐	Cancers: _____
☐	☐	Stroke	☐	☐	Family history of diabetes	☐	☐	Bone spurs
			☐	☐	Diabetes			
			☐	☐	Heart palpitations			
			☐	☐	Ulcers/ Gastritis			
			☐	☐	Gall bladder trouble			
			☐	☐	Poor circulation			
			☐	☐	Tuberculous			

FEMALES ONLY

☐☐ Menstrual irregularities
☐☐ Painful cramps/backache
☐☐ Abnormal discharge
☐☐ Birth Control Pill

# of miscarriages? ____

Are you pregnant?

☐No ☐Yes ☐Unsure

Due date? _____

Other health concerns? _____
_____
_____
_____

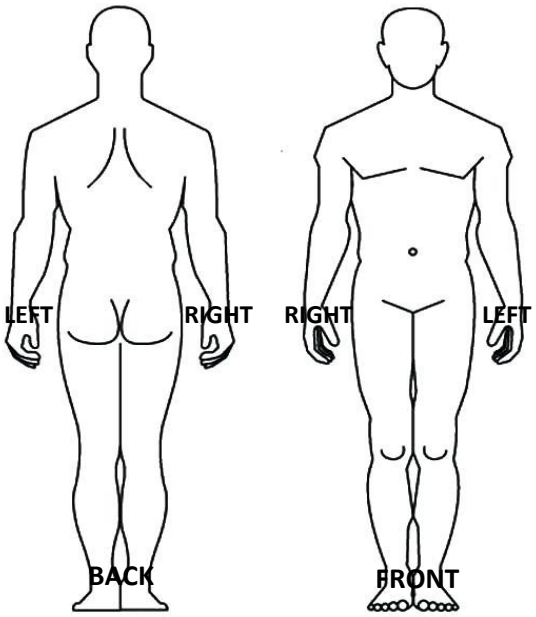
Please list any medications you are currently taking, or have taken within the past 3 months: _____
_____
_____
_____

Have you had any surgeries? If yes, please explain: ____
_____
_____
_____

List of other professionals / doctors consulted for your symptoms:

Professional: _____
Recommendations:_____
Professional:_____
Recommendations:_____

Please indicate on the diagram the area of your discomfort and any radiation of pain.



Parent/ Guardian Signature: _____ Date:_____