FOCUS FAMILY
chiropractic

Infant 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: (Mother)		(Father)	
Email address:		(Email will be used for appointment reminders, receipts, 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 his/her condition begin? _____

Has your son/daughter ever had similar problems? ☐ Yes ☐ No

Has your son/daughter had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when? _____

_____

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

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

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

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

_____

_____

Has your son/daughter had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date: _____

Did you choose to vaccinate your child? ☐ Yes ☐ No

Please check all the conditions/ illness your child has 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	☐	☐	Flatulence
☐	☐	Sinus problem	☐	☐	Rashes	☐	☐	Frequent/difficulty urinating/blood in urine
☐	☐	Strep throat/Tonsillitis	☐	☐	Nausea	☐	☐	Diarrhea
☐	☐	Recurrent fevers	☐	☐	Food Sensitivities	☐	☐	Constipation
☐	☐	Recurrent cold/flu/croup	☐	☐	Spitting up phlegm/blood	☐	☐	Blood in stools
☐	☐	Respiratory tract infection	☐	☐	Trouble feeding on one side	☐	☐	Bed wetting
☐	☐	Ear infection	☐	☐	Eczema	☐	☐	Tip toe walking
☐	☐	Allergies/Hay fever	☐	☐	Digestive problems	☐	☐	Asymmetrical gait or crawling
☐	☐	Torticollis/Head tilt	☐	☐	Constipation	☐	☐	Other: _____
☐	☐	Difficulty swallowing	☐	☐	Growing pains			
☐	☐	Visual disturbances	☐	☐	Rapid heartbeat			
☐	☐	Low energy/fatigue	☐	☐	Slow heartbeat			
☐	☐	Loss of consciousness	☐	☐	Red, painful, swollen joints			
☐	☐	Whiplash injury	☐	☐	Frequent crying spells			
☐	☐	Seizures/Convulsions	☐	☐	Heart or blood diseases			
☐	☐	Speech problems	☐	☐	Slow or aberrant reflexes			
☐	☐	Fall from change table	☐	☐	Tremors/shaking			
☐	☐	Tumble down stairs	☐	☐	Family history of diabetes			
☐	☐	Fall out of crib	☐	☐	Diabetes			
☐	☐	Fall off playground equipment	☐	☐	Autism			
☐	☐	Play in “Jolly Jumper”	☐	☐	Scoliosis			
☐	☐	Reaction to vaccination	☐	☐	Colic			
			☐	☐	Failure to thrive/slow weight gain			
			☐	☐	Sleep problems			
			☐	☐	ADD/ADHD			

Other health concerns? _____
_____
_____
_____

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

List of other professionals / doctors consulted for your symptoms:
Professional: _____
Recommendations:_____
Professional:_____
Recommendations:_____

Parent/ Guardian Signature: _____ Date:_____