Infant Intake Form

Healthworks
chiropractic & wellness centre
357 King Street, Midland, Ontario L4R 3M7
Tel: 526-6900 Fax: 526-6460
www.healthworkscentre.com

Personal History Patient No: _____ Dated: _____

Infant's Name: _____ **Address:** _____

City: _____ Province: _____ Postal Code:_____

Gender ☐ Male ☐ Female **OHIP #**_____ Birth Date: Day____/Month____/Year_____ Age: ____

Home Phone Number: _____Email Address: _____

Cell Phone Number and Provider: _____

Mother's / Guardian Name: _____Father's / Guardian Name_____

Whom may we thank for referring you to this office? _____

Current Health Conditions

Current Complaints: _____

Family Doctor _____ Does your MD know about this condition? ☐ Yes ☐ No

If yes, type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? _____

Is this condition:☐ Sports Related ☐ Auto-Related ☐ Home Injury ☐ Fall ☐ Other

Date of Accident: _____ Time of Accident: _____

What aggravates your condition?
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold ☐ Heat

☐ Dampness ☐Other _____
What relieves your condition?
☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication

☐ Other _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain:
☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Constant ☐ Inconsistent
Please describe how it feels when this problem is at its worse:

_____

Please place an X on the grade indicating the severity of your pain. Least 1 2 3 4 5 6 7 8 9 10 Most

Compare this problem at its worse and when you feel great. How does this problem at its worse interfere with?:
Your ability to go to school: _____

Your ability to enjoy your family or social time: _____

Your ability to enjoy your hobbies or sports: _____

Previous Imaging: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound

Medication, Vitamins, Supplements

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Past Health History

Please check or describe Major Surgery/ Operations:

☐ Appendectomy ☐ Tonsillectomy ☐ Broken Bones ☐ Knocked Unconscious

Hospitalization (other than the above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's name and date of last appointment _____

Were you satisfied with your chiropractic results? ☐ Yes ☐ No If no, why? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Natural Health Care.

Check any of the following diseases you have had:

☐ Cancer _____
☐ Thyroid: ☐ Hypo ☐ Hyper
☐ Eczema
☐ Diabetes: ☐ Type I ☐ Type II
☐ Depression
☐ Mental Disorder
☐ Pneumonia
☐ Whooping Cough
☐ Mumps
☐ Measles
☐ Influenza
☐ Rheumatic Fever
☐ Pleurisy
☐ Polio
☐ Chicken Pox
☐ Tuberculosis
☐ Epilepsy ☐ Seizures
☐ SARS
☐ HIV

Musculo-Skeletal Code

☐ Arthritis
☐ Osteoporosis
☐ Neck Pain
☐ Shoulder Pain
☐ Upper Back
☐ Mid Back
☐ Low Back
☐ Arm Pain
☐ Legs
☐ Knees
☐ Feet
☐ Walking Problems
☐ Difficult Chewing
☐ Clicking Jaws

Gastro-Intestinal Code

☐ Bladder Trouble
☐ Painful / Excessive Urination
☐ Discoloured Urine
☐ Black / Bloody Stool
☐ Heartburn
☐ Gas / Bloating After Meals
☐ Colitis

Nervous System Code

☐ Stress ☐ Anxiety
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Convulsions
☐ Cold / Tingling Extremities

Cardiovascular Code

☐ Stroke ☐ Heart Attack
☐ Chest Pain ☐ Short Breath
☐ Blood Pressure ☐ High ☐ Low
☐ Pacemaker
☐ Irregular Heartbeat
☐ Ankle Swelling
☐ Fainting

Respiratory Code

☐ Lung Problems
cough/congestion
☐ Varicose Veins
☐ Emphysema
☐ Bronchitis

General Code

☐ Fatigue
☐ Allergies
☐ Environmental ☐ Food
☐ Loss of Sleep
☐ Fever

EENT Code

☐ Headaches ☐ Migraines
☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

Do you have a regular exercise program.

☐ Yes ☐ No

Personal Satisfaction With Diet

☐ Highly Satisfied
☐ Dissatisfied
☐ Highly Dissatisfied

Lifestyle Stress Levels

☐ High ☐ Moderate ☐ Low

Intake

☐ Coffee Daily ____ Wkly ____
☐ Tea Daily ____ Wkly ____
☐ Alcohol Daily _____ Wkly ____
☐ Cigarettes Daily ___ Wkly ___
☐ White Sugar

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