Vital Information (Child)

Child's First Name _____ Child's Last Name _____

Child's Date of Birth D___ M ____ Y ____ Health Card Number _____

Child's Home Address _____

City _____ Province _____ Postal Code _____

Name of Parent's _____ Number of Siblings _____

Email Address _____ Home Phone _____ Business _____

Have you seen a Chiropractor before __ No __ Yes – if so, when? _____

How were you referred to The Healing Bridge? _____

Current Health Condition?

Present Complaint? _____

Present treatment for this condition? _____

When did this condition begin? _____

Are there other's in the family with this same condition? _____

What do you believe caused this condition? _____

Presently taking prescribed or over the counter medication?

_____

Is there anything about your child's Spine and Nerve System we should know about?

_____

Additional Comments

_____

Mother/Child Lifestyle History

History of physical stress, trauma or challenges during pregnancy and birth.

_____

History of chemical stress, trauma or challenges during pregnancy and birth.

_____

History of emotional stress, trauma or challenges during pregnancy and birth.

_____

What did you child have for breakfast, lunch and dinner yesterday?

_____

What is your daily fluid intake? _____

What is the quality and quantity of your child's sleep and rest?

_____

How much (and what kind of) exercise does your child get?

_____

Does your child enjoy school ___ Yes ___ No ____ N/A

Any reaction to vaccinations? _____

What does your child enjoy for play and relaxation?

_____