Brix Family Chiropractic & Wellness

Child's Name: _____
Sex: M / F Age: _____ Birthday (dd/mm/yyyy): _____

Parent(s) Name(s): _____
Address: _____ City: _____ Prov.: _____
Postal code: _____ Home Phone: _____Cell Phone:_____
Email Address: _____
How did you hear about the office? _____

Has your child ever received chiropractic care? Y / N If yes, previous DC's name and last visit date?
_____
Name of Medical Doctor: _____
Date of last MD visit and reason: _____

Current Health Complaint/Concerns
Major: _____
Minor: _____

Patient History
Please check if your child has had any of the following:

□ Headaches	□ Eating Issues	□ Weight Gain	□ Upper Back Pain
□ Dizziness	□ Light Sensitivity	□ Dental Problems	□ Neck Pain
□ Fainting	□ Face Flushed	□ Fevers	□ Low Back Pain
□ Fatigue	□ Cold Sweats	□ Heart Palpitations	□ Radiating Pain
□ Irritability	□ Bronchitis	□ Chest Pressure	□ Stiffness
□ Depression	□ Pneumonia	□ Reduced Mobility	□ Bed Wetting
□ Loss of Balance	□ Difficulty Breathing	□ Frequent Colds	□ Leg Numbness
□ Loss of Concentration	□ Shortness of Breath	□ Sinus Congestion	□ Feet Numbness
□ Loss of Memory	□ Asthma	□ Sore Throats	□ Hand Numbness
□ Ears Buzzing	□ Urinary Problems	□ Ear Pain / Infections	□ Weakness
□ Poor Coordination	□ Constipation	□ Allergies	□ Muscle Cramps
□ Vision Changes	□ Diarrhea	□ Heartburn	□ Sleeping Issues
□ Loss of Smell	□ Weight Loss	□ Bloating / Gas	

□ Other: _____

Family History
Please check any boxes that apply to anyone in your Family (not including you)
□ Heart conditions □ Cancer □ Diabetes □ Epilepsy □ Other: _____

Medications: Is your child taking medications? Y / N If yes, please list:_____
_____

Vaccinations: Has your child been vaccinated? Y / N If yes, please list: _____
_____

FOR BABIES ONLY*

History of Birth

Was the child born prematurely? Y / N If yes, how many weeks?
Birth Weight: _____ Birth Length: _____
Was your child's birth: □ at home □ in a birthing center □ in a hospital
Was the birth considered (circle): medical / midwife
What was the duration of the labour and birth? _____ hours
Was child born: □ Cephalic (head first) □ Breech (feet first)
Were there any complications: Y / N If yes, please explain: _____
_____
Please check any assistance which was used during the birth:
□ Forceps □ Vacuum Extraction □ C-Sections □ Episiotomy
Was labour (circle): Spontaneous / Induced
Were medications or epidurals given to the mother during birth? Y / N If yes, what was given? _____
_____

Legal Guardian Name: _____

Legal Guardian Signature: _____ Date: _____

Witness Signature: _____