

# Full Potential Chiropractic

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## PEDIATRIC HEALTH SCREENING FORM

By answering the following questions you will allow us to provide you and your child with the best information to support his or her optimum health. Many daily occurrences can interfere with your child's growing spine and nervous system. Spinal health is often overlooked, yet the nervous system controls every aspect of the body's functioning and warrants regular check-ups. We are here to answer your questions too!

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent's Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_  
Birth Date (DD/MM/YYYY) \_\_\_\_\_ AHC#: \_\_\_\_\_  
Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Purpose of visit: \_\_\_\_\_

Have you seen other doctors for this condition?  Yes  No  
If yes, list Doctors' name(s) and prior treatments: \_\_\_\_\_  
Please list other health problems: \_\_\_\_\_

Family history: \_\_\_\_\_

Previous chiropractor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Reason: \_\_\_\_\_

### Check any of the following conditions your child has suffered from:

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> growing pains  | <input type="checkbox"/> scoliosis       | <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> diarrhea  |
| <input type="checkbox"/> back pain      | <input type="checkbox"/> seizures        | <input type="checkbox"/> constipation       | <input type="checkbox"/> headaches |
| <input type="checkbox"/> bed wetting    | <input type="checkbox"/> car accidents   | <input type="checkbox"/> digestive problems | <input type="checkbox"/> colic     |
| <input type="checkbox"/> ADD/ADHD       | <input type="checkbox"/> temper tantrums | <input type="checkbox"/> allergies          | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> asthma          | <input type="checkbox"/> night terrors      | <input type="checkbox"/> fatigue   |

Other: \_\_\_\_\_

Your child's growing spine is extremely vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference). Check any of the following conditions your child has suffered from:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> fall in baby walker  | <input type="checkbox"/> fall from changing table | <input type="checkbox"/> fall off slide            | <input type="checkbox"/> fall off bicycle |
| <input type="checkbox"/> fall from crib       | <input type="checkbox"/> fall from bed/couch      | <input type="checkbox"/> fall off monkey bars      | <input type="checkbox"/> fall down stairs |
| <input type="checkbox"/> fall from high chair | <input type="checkbox"/> fall off swing           | <input type="checkbox"/> fall of skateboard/skates |   |

Other: \_\_\_\_\_

Does your child spend long hours at a desk, computer or watching television?  Yes  No

Does your child already show signs of poor posture?  Yes  No

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?  Yes  No, List \_\_\_\_\_

Has your child ever been involved in a car accident?  Yes  No; Describe: \_\_\_\_\_

Has your child ever been seen on an emergency basis?  Yes  No; Describe: \_\_\_\_\_

Are there other traumas not described above? \_\_\_\_\_

Has your child had any surgeries?  Yes  No

Has your child taken antibiotics?  Yes  No If yes, how many times? \_\_\_\_\_

Please list: \_\_\_\_\_

Has your child taken any other prescription medications?  Yes  No If yes, how many times? \_\_\_\_\_

Please list: \_\_\_\_\_

Vaccination history: \_\_\_\_\_

## Prenatal History

Complications during pregnancy?  Yes  No If yes, list: \_\_\_\_\_  
Medications during pregnancy?  Yes  No  
Cigarette/alcohol use during pregnancy  Yes  No

### Please check appropriate choice:

*Birth location:*  home  hospital  birth centre  
*Type of birth:*  vaginal  c-section  
*Procedures:*  forceps  vacuum  medication (mom)

Complications during delivery?  Yes  No If yes, list: \_\_\_\_\_  
Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

## Feeding History

Breast fed:  Yes  No, How long? \_\_\_\_\_  
Formula fed:  Yes  No, How long? \_\_\_\_\_  
Introduced to solids at: \_\_\_\_\_ months, Cow's milk at: \_\_\_\_\_ months  
Food/Juice allergies or intolerances:  Yes  No