evoke
WELLNESS CENTRE

Chiropractic
confidential child's intake form

Child's Name: _____ Date: _____

Date of Birth(mmm/dd/yyyy): _____ Male O Female O Other O

Address: _____ City: _____ Postal Code: _____

Name of Parents / Guardians: _____

Home Phone _____
Cell Phone _____
Email _____

Set up your appointment reminders
Text reminders Y / N
*Cell Provider*_____
Email reminders Y / N

Height: _____

Care Card # *(Premium Assistance or ICBC)*: _____ Weight: _____

How did you hear about our office? _____

If you were referred to our office who can we thank? _____

Emergency Contact Name**:** _____ Phone: _____

Previous Chiropractic Name: _____ Date of last visit: _____

Family Doctor Name**:** _____ Date of last visit: _____

Other Health Care Professionals:

Name: _____ Profession: _____

Name: _____ Profession: _____

Are your injuries related to an **ICBC** case? Yes O No O

Date of accident (mmm/dd/yyyy): _____ Claim #: _____

Adjustor's name: _____ Phone: _____

Please Note: Your appointment time has been reserved for you. We ask that you provide us with at least **24 hours notice** of cancellation. If you fail to do so the full appointment fee will apply. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I have read and understood the fee schedule and cancellation policy. I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature of parent / guardian: _____

Name: _____

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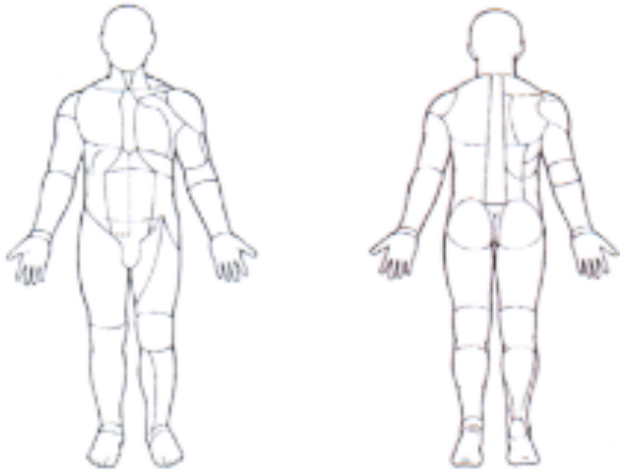
Please Check One Of The Following:

- O I have a specific health complaint that I am seeking relief for
- O I am here for a specific health complaint and am interested in strategies to help prevent its return
- O I have no specific complaints and am interested in preventative wellness care

Primary Complaint:
Please mark areas of concern:



Please describe the current condition & symptoms:

_____

_____

_____

_____

_____

_____

_____

_____

Has this complaint been experienced previously? Yes O No O If yes, when? _____

Is this condition preventing any activities? Yes O No O If yes, what? _____

Please list any medications being taken: _____

Please list any previous surgeries, accidents or trauma (include dates): _____

_____

Please list any current or past medical conditions: _____

Please list any serious allergies: _____

Has there been any recent unexplained weight loss? Yes O No O

Has there been any unexplained fever or night sweats? Yes O No O

Check any of the following conditions your child has suffered from over the past six months:

Scoliosis	ADHD	Colic	Ear Infections	Car Accident
Bed Wetting	Headaches	Seizures	Chronic Colds	Recurring Fevers
Growing Pains	Asthma	Allergies	Digestive Problems	Other _____

Please list any previous X-Ray, CT or MRI imaging taken: _____

Number of doses of Antibiotics your child has taken: _____

Vaccination History: _____

Name**:** _____

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Birth History:

Complications during pregnancy? Yes O No O_____

Complications during delivery? Yes O No O_____

Type of delivery? Vaginal O Assisted O Cesarean O

Birth weight: _____

Feeding History:

Breast Fed? Yes O No O How long?_____

Food allergies?_____

Developmental History:

Is / has your child been involved in any high impact or contact type sports (ie. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Yes O No O List: _____

Has your child ever been in a car accident? Yes O No O When? _____

Any major falls? Yes O No O When? _____

Childhood Diseases:

Chicken Pox	Yes O	No O	Age
Rubella	Yes O	No O	Age
Measles	Yes O	No O	Age
Whopping Cough	Yes O	No O	Age
Other	Yes O	No O	Age

Have we missed anything?

_____