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Form for the new Little Ones

Date:

Before we begin, we would like to know to whom we owe an immense THANK YOU! For having referred you to us:

Please fill out all questions to the best of your knowledge, and send us the form back as soon as possible, in person, by fax or by email. Mom and/or Dad can help you. Everything will be reviewed with you later.

Thank you.

Personal Information *(Please fill out with a pen)*

Last name:

First name:

Mother's name:

Father's name:

Address:

City/Town/Municipality:

Postal Code:

Home phone number:

Mom or Dads's work number:

Is it OK to leave a message at these numbers?

Mom or Dad's Email:

Can we send emails to this address including a monthly private newsletter? Yes No

Date of birth:

Do you have a pediatrician?

If yes, what is his/her name?

What year are you in at school?

Which school do you go to?

What are the names of your brothers and sisters and their ages?



Present history

Please tell us your story in your own words and pages if need be. If you are consulting us for wellness, tell us what else you are doing to support this goal. If you are consulting for a particular issue, tell us how you think this started, what has happened to you and what you have done since.



Do you have one or many congenital anomalies? Yes / No

Which ones: _____

Were you breastfed (or are you still)? Yes No

If yes, how long were you breastfed?

If no, what type of milk did you drink?

Did it go well/is it going well with both breasts?



At what age did you start to:

- ✓ Eat? And what food did you eat first?
- ✓ Walk on all fours?
 - Was it with hands and knees on the ground?
- ✓ Walk on two feet?

Did you receive routine vaccination? Yes No

Did you suffer from adverse reactions to vaccines? Yes No

If yes, describe briefly:

Have you ever...

- Had surgery? Yes / No If yes, when and why? _____
- Been a victim of falls, car collisions or other trauma? Yes No
 - If yes, when and describe briefly:
- Broken any bones or lost consciousness? Yes No
 - If yes, when and describe briefly:
- Been hospitalized? Yes / No If yes, when and why? _____

Family history

Are your father and mother in good health? Yes No

- If no, specify briefly:
- Is there a history of allergy/asthma in the family?

If you have any, are your brothers and sisters in good health? Yes No

- If no, specify briefly:

Lifestyle

Do you take any medications (drugs) ? Yes No
 If yes, which ones? Since when and at what dosage?

Did you take antibiotics before the age of one?

Do you take supplements, including vitamins? Yes No
 If yes, which ones? Since when and at what dosage?

Do you drink soft drinks? Yes No
 If yes, how many?

According to you, do you drink enough water? Yes No I do not know
 How many glasses of water do you drink per day?

Do you exercise regularly? Yes No
 If yes, what do you do? How many times per day or per week?

As a baby, were you put on your stomach and did you like it?

How many hours do you sleep per night?
 Do you nap during the day? Yes No

What position do you sleep in?

Do you sleep in your own bedroom?

Do you have a pillow?

Do you think you eat well? Yes No Are you vegetarian?
 Do you eat fish, and if so, how often?

How many portions of cow's milk do you drink every day?

How many sweets, including dessert, do you eat every day?

Do you often eat...

- Meals prepared at home Restaurant meals
- Meals prepared in advance in a store or by a company?



Systems review

Do you suffer from difficulties with...

- Your eyes – recurrent infections, cross-eyed, near-sightedness, far-sightedness, etc.
- Your ears – ear infections, hearing difficulties, hearing constant sounds, etc.

- Your nose or sinuses – congestion, frequent colds, repetitive sinusitis, allergies, etc.
- Your mouth or your throat – abscesses, frequent sore throats, etc.

- Your digestion – colic, acid reflux, difficulty digesting certain foods, allergies, etc.
- Your elimination – frequent diarrhea/constipation, bedwetting, pain when peeing, etc.
 - How often do you have bowel movements?
 - Are you diaper-free day and night?

- Your lungs and your breathing – difficulty breathing, chronic bronchitis, asthma, etc.
- Your heart– heart problems, feeling of pressure over the chest, etc.
- Your nervous or vascular system – headaches, migraines, dizziness, fainting, tremors (shaking), numbness, memory loss, etc.
- Your skin – frequent irritations, unusual pimples/plaques, psoriasis, eczema, rashes, etc.
- Your osseous and articular system – joint pains, growing pains, etc.
- Your emotional and psychological health – towards home, school, your friends, the death of a loved one, irritability, fatigue, nervousness, hyperactivity, etc.

What do you like to do best?

Expectations

What are your expectations by coming here ?



Do you wish to receive care...

- To patch, symptomatic care just to reduce pain
- To restore your health To maintain your health
- To increase your level of well-being (better-being)

Health and Quality of life are among the most precious things in this world – YOUR HEALTH AND YOUR FAMILY’S HEALTH. Chiropractic is there for You. The adjustments will help you to express your full potential of life. When you receive a chiropractic adjustment, the work has just begun. During the hours and days that follow your adjustment, your Innate Intelligence will continue to work by using the information received during the adjustment in order to make you better and so that your full healing power will be released. At the Maison Chiropratique Petits et Grands, we do not treat any condition or disease. We adjust people and the body decides, with its Innate Intelligence, what needs to be done, and what can still be done. Hence, we work in harmony with your inner wisdom. However, this process implies that you take back control of life and of your health, and that you accept to invest yourself in assisting “Dr You”.

I recognize that the given information is exact to the best of my knowledge and I consent to receive any necessary examinations.

Signature of parent

Date