

INFANT & CHILD PATIENT INFORMATION

Date _____

Dr. K.B. Jenkins, D.C.

Dr. S. Bounket, D.C.

E-mail Address: _____

Please add me to the mailing list for appointment reminders, important health information, clinic updates and newsletters

Child's Name: _____

Parent's Name(s): _____

Address: _____ City: _____ Postal Code: _____

Primary Phone: _____ Alternate Phone: _____

Date of Birth: (DD/MM/YY) _____ / _____ / _____ Gender: M / F

Alberta Health Care #: _____

Previous Chiropractic Care: Y N By Whom: _____ Last Seen: _____

Medical Practitioner: _____ Last Seen & Why: _____

Private Health Insurance? Y N Name of Company: _____

Who referred you to this office? _____

Describe your pregnancy and the birth process: (natural birth, C-section, trauma, use of vacuum, forceps, etc.) _____

Has your child had any falls, accidents, or injuries? Y N If yes, please explain: _____

Has your child ever had hospitalizations or surgery? Y N If yes, please explain and give dates: _____

Please list any current or previous health problems or illnesses: _____

Medication presently taking: _____

Purpose of visit/primary complaints: _____

Does your child have any health problems that you think chiropractic cannot help? _____

Does your baby have/had:

____ a preferred sleeping position	____ frequently arch their head/neck backwards	____ a preferred head position	____ any falls or trauma
____ feeding difficulties/preference	____ frequent spit-up after feeding	____ a lot of gas	____ constipation or diarrhea

I clearly understand and agree that all services rendered to my child that are not covered by insurance are charged directly to my account, and that I am responsible for payment of services as they are performed.

Parent/Guardian's Signature: _____