INFANT & CHILD PATIENT INFORMATION

Date_____

Dr. K.B. Jenkins, D.C.
Dr. S. Bounket, D.C.
Dr. J.S. Thomas, 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) 01 /01 /_____ 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: _____

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