

# Dr. E. Ted Frackson D.C.

## Patient History (Child age 4-10 years)

### Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred Pronouns: \_\_\_\_\_

Parents'/Guardians' Names: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Care Card Number: \_\_\_\_\_

What are your primary complaint/concern for your child?

\_\_\_\_\_

Have you consulted any other professionals regarding your child's health?

\_\_\_\_\_

### Prenatal History

Complications during pregnancy: \_\_\_\_\_

Did you carry your child to full term? Yes \_\_\_\_\_ No \_\_\_\_\_

Did you use any medications or drugs during your pregnancy? Yes \_\_\_ No \_\_\_

### Labour and Delivery History

Was your labour: Spontaneous \_\_\_\_\_ Induced \_\_\_\_\_

Medications used during labour \_\_\_\_\_

Were any of the following interventions used during delivery:

Forceps \_\_\_\_\_ Suction \_\_\_\_\_ Heavy Manual Traction \_\_\_\_\_

Was the birth a C-section? If so, was it Emergency \_\_\_\_\_ or Non-Emergency \_\_\_\_\_

Health History

In the past six months, has your child experienced:

Allergies\_\_\_\_\_ Back\_\_\_\_\_ Neck Pain\_\_\_\_\_ Digestive issues\_\_\_\_\_

Headaches\_\_\_\_\_ Bedwetting\_\_\_\_\_ Cold/Flu\_\_\_\_\_

Sleep issues\_\_\_\_\_ Ear infections\_\_\_\_\_ Food Sensitivities\_\_\_\_\_

Bowel issues\_\_\_\_\_

Developmental History

Are there any concerns in regards to learning or behavior?

\_\_\_\_\_

Activity History

How long does your child spend working at the computer/doing homework each day?\_\_\_\_\_

How much time does your child spend watching TV each day?\_\_\_\_\_

How much time does your child spend being active each day?\_\_\_\_\_

Is your child involved in any sports or extracurricular activities?\_\_\_\_\_

Trauma History

Has your child experienced any of the following:

Motor vehicle accident \_\_\_\_\_ Broken bones \_\_\_\_\_

Any other trauma that we should be aware of \_\_\_\_\_

Please keep in mind that your treatment time is reserved specifically for you. A minimum of 24 hours notice for rescheduling or canceling appointments is required. There will be a charge of \$25.00 for missed appointments or cancelations without 24 hours notice.

Please initial here to indicate you have read and understood this policy. \_\_\_\_\_

Parent's/Guardians' Signature: \_\_\_\_\_ Date: \_\_\_\_\_