Ajax Family Chiropractic ● 145 Kingston Road East, Unit 13 ● Ajax, Ontario, L1S 7J4 ● (905) 426-4116
www.ajaxfamilychiro.com Dr. Michael Gauthier Dr. Mark Kasiban Dr. Robbie Berman

Child's Name	Family Name		Date
Address	City		Postal Code
Date of Birth (M) (D) (Y)	Age:	Gender:	
Mom's Name		Dad's Name:	
Cell Phone:		Cell Phone:	
Home: Work:		Home: Work:	
Email:		Email:	
OK to MESSAGE by: ❒ Text ❒ Email OK to be CONTACTED at: ❒ Cell ❒ Home ❒Work OK to LEAVE A MESSAGE at: ❒ Cell ❒ Home ❒Work		OK to MESSAGE by: ❒ Text ❒ Email OK to be CONTACTED at: ❒ Cell ❒ Home ❒Work OK to LEAVE A MESSAGE at: ❒ Cell ❒ Home ❒Work	
Has your child ever received Chiropractic care before? ❒ YES ❒ NO If YES, When & Why:			Physician's name:

WHY THIS INFORMATION IS IMPORTANT

At **Ajax Family Chiropractic**, we focus on creating healthy families. Our goal is to understand the reason(s) that brought your child to our office and to offer your family an opportunity to improve your health through chiropractic care (wellness lifestyle). Stress on the body may be sudden or gradual, it may be harsh or subtle --- the effects are accumulative. Physical stress can come from physical trauma, injuries, or from regular activities. Chemical stress comes from pollution, but also from what one eats, and even medications. Emotional stress is life in general, family and friends on an everyday basis. Stress is a major cause of poor health because it overwhelms your body and alters your ability to adapt to your environment. By answering the following questions, you give us a profile of the stress(es) your child has faced in his/her lifetime. Understanding the challenges helps us identify what is limiting your child's ability to express true health potential. Let's figure it out together.

WHAT BRINGS YOU TO OUR OFFICE?

Did **someone suggest our Office** to you? ❒ YES ❒ NO, If YES, name _____

If not, **how did you hear about us**? ❒ My Family/Friend ❒ My Doctor/Chiropractor ❒ Live Nearby ❒ Walked In ❒ Google Review ❒ Website ❒ Internet Search ❒ Facebook/Online Advertising ❒ Other: _____

What are the **main reason(s)** for consulting our Office? _____

Has your child received **previous care** for the **main reason(s)**? ❒ YES ❒ NO

what type of care? _____

What are **your child's long-term health goals**? _____

YOUR CHILD'S CURRENT LIFESTYLE PROFILE

Is your child active in physical activities? ❒ YES ❒ NO, If YES how often? _____

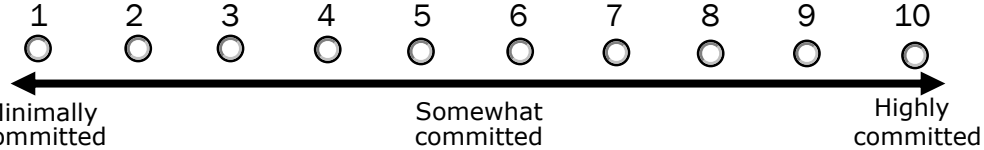
what type(s) of activities? _____

Does your child play well with other children? ❒ YES ❒ NO

Does your child drink water regularly? ❒ YES ❒ NO, how much? _____

Personal satisfaction with your child's diet? ❒ Highly Satisfied ❒ Satisfied ❒ Unsatisfied ❒ Highly Unsatisfied

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your child's health *(pick a number)*



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YOUR CHILD'S EARLY HEALTH PROFILE (REMEMBER your child's health begins before birth)

Birth process: Any problems during pregnancy? ❒ YES ❒ NO describe _____
Any problems during labour or delivery? ❒ YES ❒ NO describe _____
Was: labour induced (Pitocin)? ❒ YES ❒ NO How long was labour? _____
Was your child's delivery: ❒ vaginal? or ❒ caesarian?
Was: ❒ an epidural used? ❒ forceps used? ❒ vacuum extraction used?

Any complications after the birth? ❒ YES ❒ NO
describe_____

Was your child: ❒ breast fed (how long) _____ and/or ❒ bottle fed (starting when)_____

Early infancy: Did your child show any food allergies as he/she was introduced to solid foods? ❒ YES ❒ NO
Did your child show signs of slow development in: ❒ any movements? or ❒ thinking skills?

YOUR CHILD'S HEALTH/STRESS PROFILE

Did your child:	**as a: Infant**	**Child**	**None**
Play contact sports		❒	❒
Have any serious falls or traumas	❒	❒	❒
Get involved in any car accidents	❒	❒	❒
Have any surgeries/hospitalizations	❒	❒	❒
Use multiple courses of antibiotics	❒	❒	❒
Use medication for extended periods	❒	❒	❒

My child received vaccinations for:
❒ diphtheria, pertussis, tetanus, polio (DPT Polio)
❒ measles, mumps, rubella (MMR)
❒ influenza (flu) ❒ covid
❒ chicken pox ❒ meningitis
Others _____

List any medications your child currently takes (include all prescription and over the counter meds):
_____ _____ _____

YOUR CHILD'S MEDICAL HEALTH PROFILE

Do your child suffer from:

Mind problems such as: ❒ headaches ❒ sleep disturbance ❒ depression ❒ anxiety
❒ fainting ❒ dizziness ❒ balance ❒ **NONE**

Body problems involving: ❒ heart, circulation or blood ❒ eyes or ears ❒ joints or bones
❒ digestion or stomach ❒ sinuses, nose or throat ❒ muscles or ligaments
❒ bowel or bladder ❒ breathing, chest or lungs ❒ foot or ankle ❒ **NONE**

Conditions such as: ❒ skin infections/irritations ❒ allergies ❒ diabetes ❒ hepatitis ❒ cancer ❒ HIV ❒ **NONE**

List **any other medical condition(s)** which we should know about? _____

YOUR FAMILY'S HEALTH PROFILE

At our Office we focus on your health and well-being, as well as the health and well-being of your family and loved ones. Please list the names, ages, and any health condition(s) or concerns your family members may have:

Name, age, condition/concern(s)		**Name, age, condition/concern(s)**	
Spouse		Mother	
Children		Father	
		Siblings	

I verify the information provided is true and accurate to the best of my knowledge. I understand I am responsible for the cost of my child's care and payment is due at the time of service. By signing below, I consent to a complete health history and a comprehensive chiropractic examination (including a radiographic examination if deemed necessary by the doctor).

Typed Signature: _____ Date:_____ Dr.'s Initials: _____

We recognize that quality health care is based on a mutual understanding between you and your doctor.
We invite you to ask any questions you may have regarding care.