FILE OPENING AND ADMISSION - PEDIATRIC

D.C. : ______________________ N° of permis : ______________

PATIENT IDENTIFICATION

Name : ______________________ Last Name: ______________________ Sexe ☐ M ☐ F ☐ X

Date of birth : ______________ Age : ______________ Corrected age (prematurity): ______________

Adresse : ______________________ City : ______________________ Postal code: ______________

Referred by : ______________________

FAMILY INFORMATION

Name of parent: ______________________ Name of parent: ______________________

Telephone (residence): ______________________ Telephone (residence): ______________________

Telephone (cell): ______________________ Telephone (cell): ______________________

Telephone (work): ______________________ Telephone (work): ______________________

Email: ______________________ Email: ______________________

Occupation: ______________________ Occupation ______________________

What is the best way to reach you? ☐ Home ☐ Cell ☐ Work ☐ Email

Do you authorize the clinic to communicate with you by email? ☐ Yes ☐ No

Do you allow the clinic to leave a message at the specified number to confirm an appointment? ☐ Yes ☐ No

Holder of parental authority : ☐ Biparental ☐ Single parent ☐ Shared custody

Siblings Ages : ______________ Known health problems: ______________________

Reason for consultation ☐ In prevention ☐ For a particular problemr

Main motive : ______________________

Present since ? : ______________ How did this happen? : ______________________

Other problems? : ______________________

PRENATAL / PREGNANCY HISTORY

Health problems during pregnancy (by trimester): ______________________

Exams and tests: ______________________

Baby position (last trimester): ☐ Head down ☐ Seat ☐ Other or dont remember ______________

Prescribed medications: ______________________ Reason: ______________________

Medicines without prescriptions: ______________________ Reason: ______________________

Natural products and vitamins: ______________________

☐ Tabacco _____ /day ☐ Alcohol _____ /week ☐ Drugs _____ /week

☐ Falls ☐ Accidents ☐ Hospitalization, reason : ______________________

☐ Other: ______________________

NEONATAL AND DELIVERY

Duration of labor (regular contractions at birth)? __________ hours Duration of the push? __________ hours / min.

Place ☐ Hospital ☐Birth center ☐At home ☐ Other __________ ☐ Transfer

Vaginal :Presentation ☐Head ☐Face ☐ Seat ☐ Posterior (nose up) ☐Other __________

C-section ☐Planned ☐Not planned __________

Medications ☐Epidural ☐Pitocin ☐ Other __________

Interventions ☐ Suction cup☐ Forceps ☐Episiotomy ☐ Aspiration ☐Resuscitation ☐Other __________

☐ Shoulder dystocia ☐ bump on head ☐Marks (head, face, body) where? __________

☐Clavicle fracture ☐Other __________

☐Neonate. intensive care / hospitalization Time : __________ Reason : __________

Weight at birth : __________ ☐ g Size : __________ cm Cranial perimeter : __________ cm APGAR : __________

HEALTH HISTORY

Name of doctor: __________

Reasons & dates for consultations: __________

Illnesses since birth: __________

Illnesses in the family: __________

Autres professionnels consultés : __________

Dates des consultations : __________

Médicaments : __________

Chirurgie : __________

Accidents ou chutes : __________

How old is your child? Please answer as applicable.

Hold your head : __________

Sit alone : __________

Crawl : __________

Moving on all fours: __________

Move other than on all fours, specify: __________

Stand: __________

Walk alone: __________

Trip or fall often? __________

CONSENTS

Accuracy of information

☐ I certify that the health information provided here is, to the best of my knowledge, accurate and complete regarding my child.

Consent to review

☐ I hereby authorize the chiropractor to carry out the examinations that he/she deems necessary for the opening of my child's file. Some patients may experience discomfort or a slight worsening of symptoms following the examination. These symptoms are generally short-lived, but it is important to mention them to the chiropractor at your next visit.

__________ Name of parent

__________ Signature

__________ Date

REVIEW - FROM WALKING

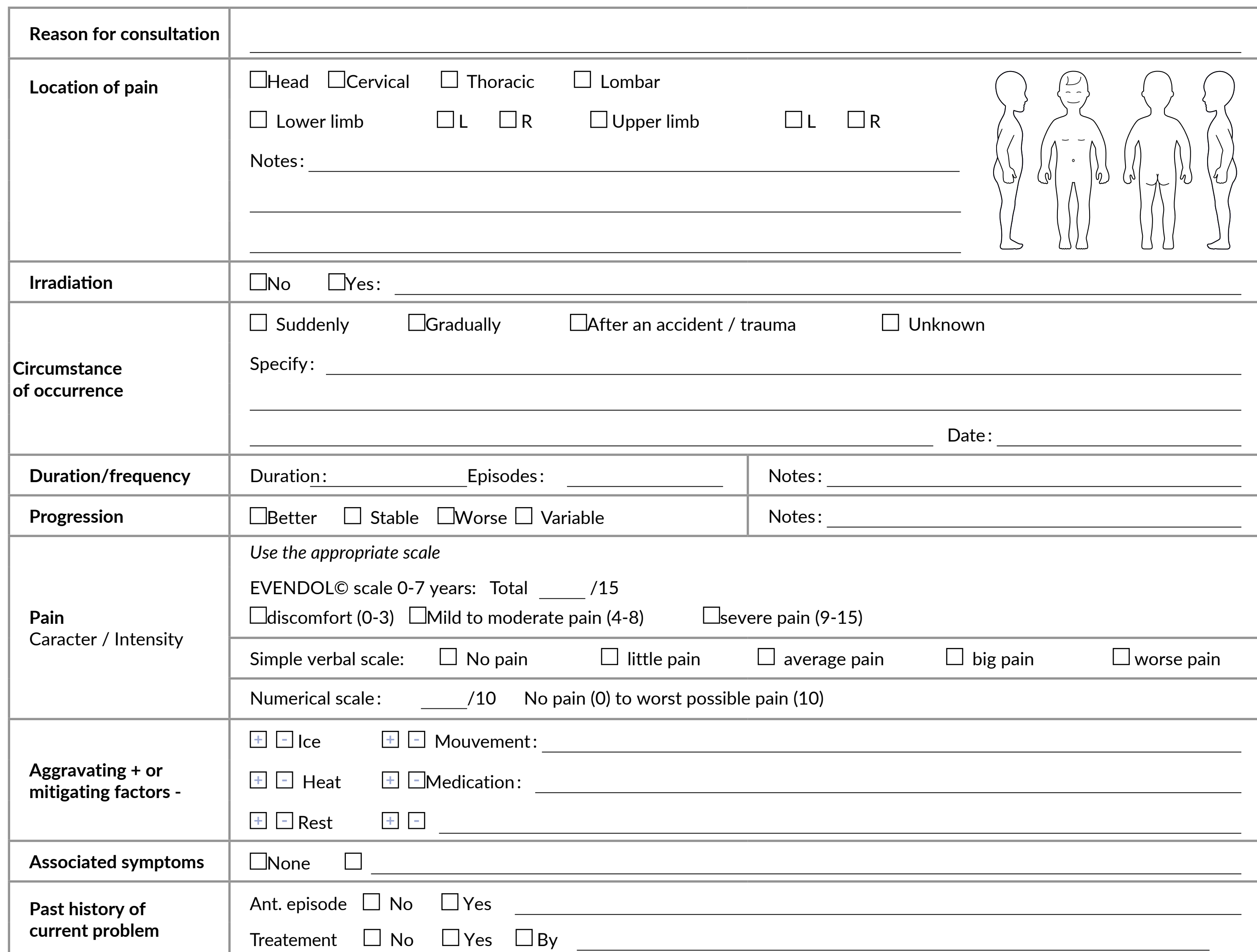
ORDRE DES CHIROPRATICIENS DU QUÉBEC

D.C. : ______________________ N° of permit : ______________________

PATIENT IDENTIFICATION

Name : ______________________ Last Name : ______________________ Date : ______________

Date of birth : ______________ Age : __________ Corrected age (up to 2 years) : __________ N° of file : ______________



Reason for consultation	______________________
Location of pain	☐Head ☐Cervical ☐ Thoracic ☐ Lombar ☐ Lower limb ☐L ☐R ☐Upper limb ☐L ☐R Notes : ______________________
Irradiation	☐No ☐Yes : ______________________
Circumstance of occurrence	☐ Suddenly ☐Gradually ☐After an accident / trauma ☐ Unknown Specify : ______________________ Date : ______________
Duration/frequency	Duration : ____________ Episodes : ____________ | Notes : ______________
Progression	☐Better ☐ Stable ☐Worse ☐ Variable | Notes : ______________
Pain Caracter / Intensity	*Use the appropriate scale* EVENDOL© scale 0-7 years: Total _____ /15 ☐discomfort (0-3) ☐Mild to moderate pain (4-8) ☐severe pain (9-15) Simple verbal scale: ☐ No pain ☐ little pain ☐ average pain ☐ big pain ☐ worse pain Numerical scale : _____/10 No pain (0) to worst possible pain (10)
Aggravating + or mitigating factors -	☐+ ☐- Ice ☐+ ☐- Mouvement : ______________ ☐+ ☐- Heat ☐+ ☐-Medication : ______________ ☐+ ☐- Rest ☐+ ☐- ______________
Associated symptoms	☐None ☐ ______________
Past history of current problem	Ant. episode ☐ No ☐ Yes ______________ Treatement ☐ No ☐ Yes ☐ By ______________

REVISION OF THE FILE OPENING FORM ☐**Nothing to add**

____

____

HEALTH HISTORY

Under investigation : ______________________

Professionnals consulted

☐Doctor ☐Specialist ☐ Dentist ☐ Physiotherapist

☐ Occupational ☐Optometrist ☐Lactation consultant

☐ Nurse ☐Other : ______________

Medication and supplements : ______________________

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Accident ☐HX½ ☐No ______________

Trauma ☐ HX½ ☐No ______________

?í ½X½ ☐ HX½ ☐ No ______________

Hospitaliùation ☐HX½ ☐No ______________

____

INITIALS	

PREGNANCY, BIRTH

____

____

____

FOOD

☐ IntolErances / Food allergies ______________

____

____

pGALS SCREENING

☐ Pain or stiffness in your muscles, joints and back? ______

☐ Difficulty dressing alone without help? ______

☐ Difficulty going up or down stairs? ______

SLEEP

Sleep pattern : ______________

Sleep concerns? ☐Yes ☐No

X-RAYS, INVESTIGATIONS AND SPECIALIZED EXAMINATIONS

☐ X-Rays ☐ None

☐ Specialized exams ☐ None

☐ Other investigations ☐ None

To come : ______________

____

ACTIVITIES

Physical activity: ______________

How much? ______ Frequency ______

Screen time ______________

FAMILY HEALTH HISTORY

Parent 1 : ______________

Parent 2 : ______________

Siblings : ______________

Hereditary disease in the extended family : ______________

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____

____

SYSTEMS REVIEW

Dermatological	☐ Eruption ☐ Eczema
Respiratory	☐Asthma ☐Shortness of breath ☐ Difficulty breathing ☐ Snoring ☐Recurrent cough ☐ Secretions ☐Wheezing
Digestive	☐Gastroesophageal reflux ☐ Pain ☐Vomiting ☐Gas ☐ *Stools (abnormal frequency, mucus, blood)*
Cardiovascular	☐ Heart murmur ☐Heart disorder ☐ Palpitations ☐ Arrhythmia
Musculoskeletal	☐Torticollis ☐ Sprain ☐ Fracture ☐ Back, arm, leg pain ☐Posture problem ☐Lower limb alignment
Neurological	☐ Numbness ☐ Tremors ☐ Anxiety ☐Nervousness ☐ Insomnia ☐ Difficult sleep ☐ Attention/concentration ☐ Motor skills problem ☐ Communication/language problem
ENT	☐ Earache ☐ B ☐ G ☐ D When ______ ☐ Sinus problems
Urinary	☐ Pain ☐ Blood ☐ Infection ☐ Incontinence ☐Frequent urination ☐ Enuresis (bedwetting)
Development	☐ Developmental difficulties or delays, not following expected developmental milestones or like other children their age

Any other health concerns or information not previously mentioned?

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OTHERS / ADDITIONS / COMMENTS

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INITIALS	