FILE OPENING AND ADMISSION - PEDIATRIC

ORDRE DES CHIROPRATICIENS DU QUÉBEC

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 - BIRTH TO 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: _____

The motif of consultation	_____ _____
Circumstance of occurrence	☐Since birth ☐Gradually ☐Suddenly ☐Other Date of occurrence: _____
Duration/frequency	_____
Progression	☐ Better ☐ Stable ☐Worse ☐ Variable
Pain	EVENDOL© Scale : Total _____ /15 ☐Incomfort (0-3) ☐Mild to moderate pain (4-8) ☐Intense pain (9-15)
Aggravating + or mitigating factors -	☐None + _____ - _____
Associated symptoms	☐None ☐ _____
Past history of current problem	Ant. episodes. ☐ No ☐ Yes _____ Treatment ☐No ☐ Yes ☐ By _____

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

_____

_____

HEALTH HISTORY

Under investigation: _____

Professionnels consulted

☐ Doctor ☐Specialiste ☐Dentist ☐ Physiotherapist

☐ Occu. Therapy ☐Optometrist ☐ Lactation consultant

☐ Nurse ☐ Autre _____

Medication et supplements: _____

ACCIDENTS, TRAUMA, SURGERIES AND HOSPITALIZATIONS

Accident ☐Yes ☐No _____

Trauma ☐Yes ☐No _____

Surgery ☐Yes ☐No _____

Hospitalization ☐Yes ☐No _____

_____

PREGNANCY, BIRTH

_____

_____

_____

FOOD

☐Exclusive breastfeeding ☐Mixed breastfeeding ☐Bottle ☐ Teterelle ☐ Other _____

☐ Breast milk (lm) ☐ Commercial milk formula (PLC)

☐ Number of drinks/day _____ ☐ Difficulties _____

☐ Integrated complementary foods ☐ Difficulties when feeding _____

☐Food intolerances / allergies _____

INITIALS	

SLEEP

Sleeping position ☐Back ☐ Stomach ☐Sides

Quality of sleep ☐Good ☐ Medium ☐ Poor

TEARS

Time : _____Frequency: _____ ☐Excessive

Consolable? ☐ Yes ☐ No

Associated symptoms or behaviors?

☐Touches his ears ☐Other _____

Can the baby be dropped off?☐ Yes ☐ No _____

TUMMY TIME

DV: Time per day (approximate) _____# of x/d: _____

FAMILY HEALTH HISTORYE

Parent 1: _____

Parent 2: _____

Siblings: _____

Hereditary disease in the extended family: _____

X-RAYS, INVESTIGATIONS AND SPECIALIZED EXAMINATIONS

☐ X-Rays ☐None

☐Specialized examinations ☐None

☐Other investigations ☐ None

To come: _____

_____

SYSTEMS REVIEW

Dermatological ☐ Rash ☐ Eczema

Respiratory ☐Shortness of breath ☐Difficulty breathing ☐Recurring cough ☐Secretions ☐ Wheezing ☐ Stridor

Digestive ☐Regurgitation ☐Gastroesophageal reflux ☐Vomiting ☐Stomach aches ☐ Colic ☐ Gas

☐Stools *(abnormal frequency, mucus, blood)*

Cardiovascular ☐Heart murmur ☐Heart disorder

Musculoskeletal ☐Torticollis ☐Sprain ☐ Fracture ☐Back, arm, leg pain ☐Ligament hyperlaxity

Neurological ☐ Posture problem ☐Cranial asymmetry

☐Tremors

ENT ☐Earache ☐ Sore throat

Urinary ☐Pain ☐Blood ☐ Infection ☐Abnormal urination

Development ☐ Developmental difficulties or delays, does not follow expected developmental milestones or like other children of his or her age

Any other health conditions or information not previously mentioned?

_____

_____

OTHERS / ADDITIONS / COMMENTS

_____

_____

_____

_____

_____

INITIALS	