CHILDREN'S ADMITTANCE RECORD

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR COOPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS.
PLEASE PRINT – THANK YOU

DATE: _____ ***HEALTH CARE NUMBER:*** _____

PERSONAL:

Name _____ Home Phone_____

Home address _____ City_____ Postal Code _____

Date of birth: Month:_____ Day:_____ Year:_____ Weight_____ Sex: M / F

Mother's Name:_____ Mother's Cell or Work Number: _____

Father's Name: _____ Father's Cell or Work Number: _____

Number of siblings: Brothers _____ Sisters _____

Name of medical doctor: _____

Reason for child's visit: _____

LIFESTYLE QUESTIONS:

1. CHILD spends most of the day with:
   a) Mother b) Father c) Grandparents d) Sitter e) Daycare f) Kindergarten g) Other
2. Circle the letter that indicates your child's hand of dominance: a) Right b) Left
3. Did your child have any prior health problems that they have outgrown or have been corrected?
   NO_____ YES_____ If yes, please explain: _____
4. What is the child's bedtime? _____ Number of hours of sleep per night: _____
5. Quality of sleep: a) Good b) Fair c) Poor d) Restless
6. Does your child awaken frequently with a regular complaint? NO_____ YES_____
7. RECENTLY, has your child awakened complaining of pain? NO_____ YES _____
8. Would you describe your child's health as: a) Robust b) Very good c) Average d) Poor e) Sickly
9. Has there been a change in the child's energy level? NO _____ YES _____
   If Yes, is it Higher _____ or Lower _____
10. Has there been a recent change in the child's strength? NO _____ YES _____
11. Are there any concerns regarding the child's diet? NO _____ YES _____ Explain: _____
12. At what age was the child potty trained? _____
13. Are you concerned with any of the following regarding bowel and bladder function?
    a) Regularity b) Stool consistency c) Pain with bowel movements d) Bedwetting

CHILDREN'S HEALTH HISTORY:

1. Please check any of the following if they are a concern to you:
   Mouth breathing _____ Snoring _____ Tonsillitis _____ Recurrent ear infection _____
   Hoarseness _____ Recurrent throat infections _____ Difficulty breathing _____
   Watery or swollen eyes _____ Sinus infection _____ Recurrent eye infection _____
2. Please check any occurrence of childhood diseases or conditions:
   Mumps _____ Measles _____ Chicken pox _____ German measles _____ Baby Measles _____
   Anaemia _____ Thrush _____ Hernia _____ Undescended testicles _____

3. Does your child complain of pain or soreness in the legs, knees, ankles, or feet? NO_____ YES _____
4. Does your child complain of pain or soreness in the arms, elbows, wrists, or hands? NO____ YES____
5. Is your child currently (or recently) taking any of the following medications?
   a. Antibiotics? NO____ YES ____ For what? _____
   b. Tylenol or Aspirin? NO_____ YES_____ For what? _____
   c. Other medications? NO_____ YES _____ For what? _____
6. Is your child following an immunization program? NO_____ YES_____
7. Has your child had any reaction to the immunization? NO _____ YES_____
8. Has your child had any allergic reaction to any medications? NO_____ YES_____
9. Does your child have any problem with dry scaly skin or persistent rashes? NO_____ YES_____
10. Is your child showing any signs of having asthma or bronchitis? NO_____ YES_____
11. Has your child been examined by an allergist? NO_____ YES_____
12. Is your child having allergy shots? NO_____ YES_____
13. Has the child EVER been hospitalized NO_____ YES_____ Why? _____
14. Has the child had any broken bones? NO_____ YES_____ What? _____
15. Has your child ever experienced a dislocation? NO_____ YES_____
16. Has your child ever been involved in a motor vehicle accident? NO_____ YES_____
17. Has your child ever received any major trauma? NO_____ YES_____
18. Has your child ever had trauma to the spine? NO_____ YES_____
19. Has there been a problem with the child's walking? NO_____ YES_____
20. Do you have any concern regarding your child's walking pattern? NO_____ YES_____
    a) Limp b) Toe walking c) Scoliosis d) Pain e) Foot positioning f) Unusual shoe wear G) Other
21. Date of last visit to medical doctor: _____ Dr.'s name:_____
    Purpose: _____