CHILD HISTORY

(PLEASE PRINT) Male ☐ Female ☐ Date: _____

Name: _____ **MB Health Card #** _____ / _____
6 digit **9 digit**

Address: _____ Phone (H): _____
(Box/Street) (City) (Postal Code)

Birthday (D/M/Y): _____ Age: _____

Email: _____
☐Monthly Newsletter ☐Birthday Greetings ☐Appointment Reminders

Parent's Name(s): _____ Referred By: _____

Has this child had prior chiropractic care? Yes ☐ No ☐ By Whom? _____

For what condition? _____ Date of Last Adjustment: _____

Is this child covered by any type of Private or Group Health Insurance?

Company: _____ Contract #: _____ Group #: _____

PLEASE LIST THE MAIN COMPLAINTS: _____

How long has your child had these complaints? _____

List other doctors consulted for these conditions: _____

What was their opinion/treatment? _____

Did this child have a difficult birth? _____ Where forceps used? _____

Has this child had any personal injuries or been hospitalized? (Explain) _____

Is this child on any prescription medication? List: _____

Does this child play sports? _____ Which ones: _____

Please circle any conditions that apply to your child:

Attention deficit	Allergies	Asthma	Stomach pains	Poor posture
Poor appetite	Poor sleep	Headaches	Bed wetting	Stuttering
Growing pains	Hyperactivity			

I hereby authorize Dr. Lori Ann Petrilli/Dr. Lawrence Schledewitz (chiropractors), and whomever they may designate as their assistants, to administer chiropractic care as they deem necessary to my child.

Signed: _____ (parent/guardian)

Witnessed: _____

Thank-you for taking the time to fill out this form!