ALIGNMENT FOR LIFE • Dr. Christina Clapham
10384 Bowerbank Road, Sidney, BC V8L 3L7
Ph: 778-426-1006 email: reception@alignmentforlife.ca
www.alignmentforlife.ca

WELCOME TO OUR OFFICE

New Client Information Form (Pediatric)

Date_____

Last Name _____ First Name _____ Care Card PHN#_____

Birth date (M/D/Y) _____ Age _____Female ____Male _____Weight _____Height _____

Address_____ City _____Postal Code_____

Home Phone _____Parent's work phone_____

Parent/Guardian Names_____

Purpose for contacting us?_____

Other doctors seen for this condition? Y__ N__ List names and treatments_____

_____

Other health problems? _____

How did you find out about our office? Whom may we thank? _____

Your Child's Health Profile

General History

Ear infections	Y___N___?___	Asthma/Allergies	Y___ N___?___	Colic	Y___N___?___
Scoliosis	Y___N___?___	Digestive problems	Y___N___?___	Bed wetting	Y___N___?___
Seizures	Y___N___?___	Auto accidents	Y___N___?___	Chronic colds	Y___N___?___
Recurring fevers	Y___N___?___	Temper tantrums	Y___N___?___	Headaches	Y___N___?___
ADHD	Y___N___?___	Other	Y___N___?___		

Health History

Name of pediatrician _____Date of last visit _____ Reason_____

Number of doses of *antibiotics* you child has taken:

In the last six months: _____ Total during his/her life_____

Number of doses of other *prescription medications* your child has taken:

In the last six months: _____ Total during his/her life_____

Vaccination History:_____ Any reactions to Vaccination? Y___N___

Detailed History

Prenatal History

Complications during pregnancy? Y___N___ Describe_____

Ultrasounds during pregnancy? How many?_____ Cigarette/alcohol use during Pregnancy? Y___N___

Medications during pregnancy/delivery? Y___N___ Please list _____

Location of birth: Hospital___ Home___ Other_____

Delivery complications? Y___N___ Describe _____Birth interventions?_____

Birth stats: Weight_____ Length_____ APGAR scores_____

Childhood diseases

Chicken Pox? Age: _____ Rubella? Age: _____ Whooping Cough? Age: _____

Rubeola ? Age: _____ Mumps? Age: _____ Other diseases? _____Age _____

Traumas

Car accidents? Y___N___ Describe: _____

High falls? Y___N___ Describe: _____

Surgery? Y___N___ Detail: _____

At what age was your child able to?

Respond to sounds _____ Cross crawl _____Respond to visual stimuli? _____

Stand alone _____Hold head up _____Walk alone _____Sit up_____

I hereby authorise Dr. Christina Clapham to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature _____ Date_____

Relationship to patient_____