Dr. Melanie Beingessner
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PreSchool Child Patient Information Form (Age 1-4)

Personal Information

Today's Date: _____

Child's Name: _____ Sex: _____

Birth Date: _____ Age: _____ Weight: _____ Height: _____

Mother's Name _____ Father's Name _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone #: _____ Mom's Work Phone: _____ Dad's Work Phone: _____

AHC #: _____ Email address: _____

We send out monthly newsletters to our patients. May we have your permission to send one to you? ❒ Yes ❒ No

Signature: _____ Date: _____

Do you have extra health insurance? (AB Cross, Greenshields, etc.) _____

Who is your medical doctor? _____

Did anyone refer you to this office? (if so, who?) _____

Has your child been to a chiropractor before? If so, who? _____

Present Health Challenge(s)

What is your child's health challenge that you are concerned about? _____

_____

What do you feel is the cause of your child's problem? _____

_____

_____

When did you first notice this sign of body dysfunction? _____

_____

Is this dysfunction getting progressively worse? ❒Yes ❒ No

If yes, why do you think so? _____

_____

What are the most significant measures you have taken to date to improve your child's present health challenge? _____

_____

_____

Please list all the healthcare practitioners seen, treatments rendered, and any results experienced.

_____

_____

_____

_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today. _____

_____

_____

_____

_____

Current Health History

Average hours of sleep per night: _____ Quality of sleep: ❑ good ❑ fair ❑ poor

How many times per night is your child waking up? _____

Please check any of the following health challenges your child has suffered and/or continues to suffer from:

❒ Allergies	❒ Frequent colds/flus	❒ Asthma	❒ Upper respiratory infections
❒ Ear infections	❒ Colic	❒ Reflux/Spitting Up	❒ Thrush/ chronic diaper rash

Please indicate if your child has had any of these diseases and if so, approximately when.

❑ Chickenpox _____ ❑ Whooping Cough _____ ❑ Other _____
❑ Measles _____ ❑ Mumps _____ ❑ Other _____

Immunization history: _____

_____

_____

Birth History

Type of Birth: ❑ Vaginal ❑ Breech ❑ Cesarean

Were forceps used? ❑ Yes ❑ No Was vacuum extraction used? ❑ Yes ❑ No

Any problems during pregnancy? _____

_____

_____

_____

Any problems during labour or birth? _____

_____

_____

_____

Any concerns after labour or birth? _____

_____

_____

_____

Developmental History:

At approximately what age did your baby:

_____	Respond to sound	_____	Crawl
_____	Follow an object with his/her eyes	_____	Stand
_____	Hold head up	_____	Creep about
_____	Sit alone	_____	Walk alone

Physical Health

Accidental trauma is the number one cause of injury to children in Canada. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

_____

_____

_____

_____

Has your child ever been hospitalized? ❒ Yes ❒ No

If yes, why and when? (Please list in chronological order) _____

_____

_____

_____

Gut Health

Is/was your child breast fed? ❒ Yes ❒ No If yes, for how long? _____

Is/was your child formula fed? ❒ Yes ❒ No If yes, what type of formula and for how long? _____

_____

At what age did you introduce solid foods into your child's diet? _____

What food did you start with? _____

_____

_____

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacterial infections?

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

_____

_____

_____

On a scale from 1-5, please rate the food groups that are most eaten by your child every day.

1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
None ⟷ Lots	**None ⟷ Lots**	**None ⟷ Lots**	**None ⟷ Lots**
Non-Complex Carbohydrates	**Complex Carbohydrates**	**Protein**	**Fats**
Bread products, cereals, pizza, cake, cookies, chocolate, candy, pop	Fruits and vegetables	Meats, eggs, nuts, seeds	Dairy Products, margarine, oils

Please list the 3 most common foods eaten by your child each day:

1. _____
2. _____
3. _____

How many times per week does your child eat fast food? _____

What type? _____

_____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink pop or carbonated beverages? ❒ Yes ❒ No If yes, how much per day? _____

Does your child consume artificial sweeteners such as aspatartame, Splenda, sucralose? ❒Yes ❒ No

If yes, what type of artificial sweeteners does your child use? _____

Has your child exhibited any intolerance and/or allergy to any specific foods? ❒ Yes ❒ No

If yes, please list all foods. _____

_____

_____

Has your child been tested for allergies? ❒ Yes ❒ No

If yes, how were the tests performed? _____

What were the results? _____

_____

_____

_____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ear/nose/throat/respiratory symptoms, digestive symptoms)_____

_____

_____

Has your child received treatment for any type of allergy? ❒ Yes ❒ No

If yes, what type of treatment? _____

_____

_____

_____

Additional Information

How many hours of television per day does your child watch on average? _____

Is there anything else that concerns you, or anything else that you would like Dr. Melanie to know? _____

_____

_____

_____

_____

What are your child's strengths? _____

_____

What are your child's weaknesses? _____

_____

Authorization For Care Of A Minor

Child's Name: _____ Age: _____

Mother's Name _____ Father's Name _____

I hereby authorize this clinic and Dr. Melanie Beingessner, Professional Corporation, to administer care, as she deems necessary to my son/daughter/ward. I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Signature: _____ Date: _____

Witnessed: _____ Date: _____