

OWERS CHIROPRACTIC
DR WENDY OWERS
120 Ottawa Street North Unit 201
Kitchener, ON N2H 3K5
519-744-3091
www.owerschiropractic.com

PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____ Mother: _____ Father: _____
Address: _____
City/Town: _____ Postal Code: _____
Home #: _____ Mother's Work #: _____ Father's Work #: _____
Birth Date: ___ ___ ___ Age: _____ Sex: M F # of Siblings: _____
Birth Weight: _____ Current Weight: _____
Birth Length: _____ Current Length: _____
Type of Birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____
Home _____ Birthing Centre _____ Hospital _____
Apgar Scores: _____ Was there presence at birth of: _____ Jaundice
_____ Cyanosis
Congenital Anomalies/Defects: _____
Infant Feeding: Breast _____ Bottle _____ Formula _____
of Hours Sleep Per Night _____ Quality of Sleep: Good ___ Fair ___ Poor ___
Obstetrician/Midwife _____ Address: _____
Pediatrician/Family MD: _____ Address: _____
Date of Last Visit to MD: _____ Purpose: _____
Immunization History: _____
Purpose of this appointment: _____
Has your child been treated on an emergency basis? _____
Describe: _____

AUTHORIZATION FOR EXAMINATION OF A MINOR

I hereby authorize this clinic and its doctor(s) to administer any of the following examinations up to and including but not limited to: physical, neurological, orthopedic and/or radiographic as appropriate to my child's/ward's history and present status as determined by the consulting doctor.

Signed: _____ Witnessed: _____ Date: ___ ___ ___

OWERS CHIROPRACTIC
DR WENDY OWERS
120 Ottawa Street North Unit 201
Kitchener, ON N2H 3K5
519-744-3091
www.owerschiropractic.com

NAME _____
DATE _____

PEDIATRIC CASE HISTORY - INFANT

Pregnancy

History: _____

Delivery/Birth

History: _____

Present

History: _____

Surgery: _____

Medications: _____

Accidents: _____