Two Souls Yoga
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-522-6222
Fax: 705-522-6222
info@twosoulsyoga.com
www.twosoulsyoga.com

Dr. Kassandre Goupil, DC

CHILD INITIAL INTAKE FORM

Child's Name: _____**Initial Visit Date**:_____

Birthdate: _____ Sex: M / F Ht: _____ Wt: _____Family Doctor: _____

Please list any medications child is currently taking:

_____

Contact Information: *(please check off primary contact person and preferred method(s) of contact)*

☐Parent/ legal guardian (s) name:_____

☐ Home phone #: _____

☐ Cell phone #: _____

☐ Work phone #: _____

☐ Email Address: _____

Secondary Contact (Name & Phone #):

_____

If more than one residence, please check off which address should be listed for receipts:

☐ Address 1: _____ City: _____ Postal Code: _____

☐ Address 2: _____ City: _____ Postal Code: _____

Can Dr. Kassandre Goupil use your email address to contact you concerning your childs' care? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Talks/events ☐ Other: _____

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MAIN HEALTH CONCERNS

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Family Medical History:

Has anyone in your family had any of the following diseases/conditions?

☐ Hypertension ☐ Heart Disease ☐ Lung Disease ☐ Cancer – type: _____

☐ Stroke ☐ Tuberculosis ☐ Epilepsy ☐ Diabetes

☐ Alzheimer's Disease ☐ Scoliosis ☐ Osteoarthritis☐☐ ☐ Ankylosing Spondylitis

☐ Multiple Sclerosis ☐ Osteoporosis ☐ Gout ☐ Rheumatoid Arthritis

☐ Psoriasis ☐ Scoliosis ☐ Low Back Pain ☐ Disc Disease

☐ Migraine Headaches ☐ Scarlet Fever ☐ Polio ☐ Diphtheria

☐ Shingles ☐ Alcoholism ☐ Malaria ☐ Anemia

☐ Other (specify):

_____

_____

Pediatric Health Questionnaire

Please complete this questionnaire. Your answers will help us in the complete assessment of your child's spinal health.

Purpose of this office visit: ☐ Spinal Check up ☐ Other(please specify):_____

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Please Tell Us About:
Pregnancy - Please check off any applicable conditions/issues:

☐ Toxemia ☐ Diabetes ☐ Pre-Eclampsia ☐ Hypertension ☐ Water Retention

☐ Allergies ☐ Food Sensitivities ☐ Nausea/Vomiting ☐ Heartburn ☐ Back pain

☐ Other:

_____

Delivery/Neonatal Life

Was child Full-term? ☐ Yes ☐ No - # weeks early _____ # weeks late _____
How long was labour? _____ hrs

Were you induced? ☐ Yes ☐ No How? ☐ Vaginal ☐ Intravenous Any medication used? _____ Please check off all the following that apply:

☐ Episiotomy ☐ Epidural ☐ Vaginal delivery ☐ C-section ☐ Forceps ☐ Vacuum Extraction

☐ Anoxia ☐ Jaundice ☐ Blood Transfusions ☐ Other complications (specify):

_____

Infancy/Childhood

What position does your child sleep in? ☐ Side ☐ Back ☐ Front Has child ever had a postural analysis? ☐ Yes ☐ No Has your child ever been suspected of having/diagnosed with any of the following:

☐ Poor posture ☐ Scoliosis (spinal curvature) ☐ Kyphosis/Lordosis ☐ Hip dysplasia

☐ Leg length inequality ☐ Flat feet ☐ Muscular torticollis

Has child ever been hospitalized? ☐ Yes ☐ No – Reason:

_____

Has child ever had surgery? ☐ Yes ☐ No – Reason:

_____

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Has child ever experienced any of the following health problems?

□ Colic □ Allergies □ Bronchitis □ Pneumonia □ Recurrent colds/flu □ Food/drug reactions

□ Asthma □ Seizures □ Diabetes □ Ear infections □ Other (specify):

_____

Has child had any of the following infectious childhood diseases?

□ Influenza □ Mumps □ Measles □ Rubella □ Poliomyelitis □ Chicken Pox□□□□□ Mononeucleosis

□ Tuberculosis □ Hepatitis □ Meningitis □ Other (specify):

_____

Has child been immunized? □ Yes □ No Has child ever had an adverse reaction to vaccines? □ Yes □ No
Please describe reaction:

_____

Has your child ever had any of the following?

□ Fracture/dislocation □ Concussion □ Whiplash □ Head trauma □ Sports injuries
Please describe:

_____

Has child had any major falls? □ Yes □ No Describe:

_____

Has child been involved in a car accident? □ Yes □ No Describe:

_____

Has child had previous chiropractic care? □ Yes □ No Dr. _____ Reason: _____

Previous x-rays? □ Yes □ No Date: _____ Reason: _____

What is the frequency of child's bowel movements? _____ Consistency? _____

Does child experience discomfort or pain associated with bowel movements? □ Yes □ No

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Informed Consent and Request for Chiropractic Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Kassandre Goupil will discuss the potential benefits, risks and alternatives involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____	_____	_____
Patient Name	Parent/ Legal Guardian Signature	Date