Dr. Gavin Morphet
911 Golf Links Rd. Suite 101
Ancaster, ON L9K 1H0

PEDIATRIC HEALTH HISTORY

Name: ___________________________ Gender: Male ___ Female ______
Address: ____________________________________ City: __________________
Postal Code: ____________Home Phone: _____________
Date of Birth: D____ M ____ Y ____ Age: _______
Family Doctor: ________________ Father's Name: ___________________________
Mother's Name: _____________________________
Has your child ever received chiropractic care? Yes ____ No _____
If so, where, when and who? ____
Who referred you to us? ____
If not referred, how did you hear about the clinic? _____________________________

Do you have health insurance coverage? Yes _____ No _____
If yes: Does it cover chiropracitc care Yes ____ No _____ Amount ____________
Does it cover massage therapy Yes ____ No _____ Amount ____________
Does it cover naturopathic care Yes ____ No _____ Amount ____________

HEALTH EVENTS

	Yes	No
Has your child ever been in a motor vehicle accident?	____	____
Has your child ever been hospitalized?	____	____
If yes, please describe: ____		
Does your child have any allergies?	____	____
If yes, please describe: ____		
Does your child take any medications?	____	____
If yes, please describe: ____		

Has your child ever been diagnosed with any of the following:

Cancer ____ Heart Problems ____ Diabetes ____

Asthma _____ Other: ___________

If your child has a specific primary complaint, please describe below:____________________
____
____

How and when did the problem start? ____
____
____