Children's Health History

To help us serve you better, please complete the following information.

Name: ____ Date:______________________

Address: ___________________________ City: _____________Postal Code: ________________

Date of Birth:________________________ Phone:______________________________________

Mother's / Guardian's Name______________________________ Work Ph: __________________

Father's / Guardian's Name ______________________________ Work Ph: __________________

Who may we thank for referring you to our office? ______________________________________

Reason for contacting our office: ____

____

Other professionals seen for this concern: ____

Please list treatments and results: ____

Other health concerns: ____

____

Family health history: ____

Previous Chiropractor: _________________________Date of last visit: ______________________

Name of Pediatrician: ____

Date of last visit: ______________________Reason: ____________________________________

BIRTH HISTORY

Please check all that apply: Hospital Home Birth Birthing Center Midwife Forceps Vacuum Extraction C-Section Induced Labour

Other complications during birth? No Yes: ____

Medications given to mother during labour? No Yes: __________________________________

Duration of birth: ________ hours APGAR at birth: ________ APGAR after 5 minutes: ________

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, explain: ____

GROWTH & DEVELOPMENT

Any signs that your child is not developing properly? No Yes: _____________________________

Any growing pains? No Yes: ____

How many times has your child been sick in the last year? _________________________________

Do sleeping patterns seem normal to you? Yes No: ____________________________________

CHEMICAL STRESSORS

Please rate on a scale of 1-10 (10 being the best) the mother's diet during pregnancy: ____________

Mother smoked during pregnancy? No Yes Any smokers at home? No Yes

Drugs taken during pregnancy? No Yes If yes, which ones: ________________________________

Ultrasounds during pregnancy? No Yes If yes, how many? ________________________________

Any invasive procedures (amniocentesis, CVS)? No Yes: __________________________________

Was this child breast fed? No Yes If Yes, for how long? __________________________________

Was formula introduced? No Yes, at what age? ____

Was cow's milk introduced? No Yes, at what age? _______________________________________

Food intolerances? No Yes If yes, which foods? ____

Number of doses of antibiotics your child has taken: ______________________________________

Other prescription medication your child has taken: ______________________________________

Vaccination history: ____

Vaccine reactions (please circle): high pitched screaming, non-stop crying, fever, rashes hives, convulsions, seizures, other: ____

Any digestive problems? No Yes: ____

Any skin problems: No Yes: ____

EMOTIONAL STRESSORS

Please rate on a scale of 1-10 (10 being the most) the mother's stress during pregnancy: __________

Was this child allowed to bond immediately after delivery? No Yes

Any behavioural problems? No Yes: ____

Any night terrors, sleep walking, or difficulty sleeping?

Average number of hours of television/computer/ipad/ipod/video games per week? _____________

PHYSICAL STRESSORS

Any traumas during pregnancy? No Yes

Any evidence of birth trauma: bruises odd shaped head s tuck in birth canal excessively long birth respiratory problems cord around neck other: ___________________

Any falls from couches, beds, change tables? No Yes: ____________________________________

Any traumas with bruising, cuts, stitches, fractures? No Yes: ______________________________

Any hospitalizations? No Yes: ____

Any surgeries or organs removed? No Yes: ____

Sports played and age began? ____

Weight of school backpack? ____

I authorize this office and its doctors to deliver care to my child as they deem necessary. I understand and agree that I am responsible for payment of all associated fees.

Guardian's Signature: ___________________________________ **Date:** _______________________

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.
I intend this consent to apply to all my present and future chiropractic care.

PLEASE DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

Dated this_________ day of _______________. 20_______.

_________________________________ ______________________________________

Patient Signature (Legal Guardian) Signature of Chiropractor

Name:___________________________
(please print)